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The Illinois Medical Journal

The Official Journal Of

The Illinois State Medical Society

INDEX TO VOLUME 94

July — December, 1948

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NEW YORK ACADEMY
OF MEDICINE

267831

Index To Volume 94

Issue	*Pages*	*Issue*	*Pages*
July	1-80	October	209-276
August	8-148	November	277-336
September	149-208	December	337-390

This index is arranged under the following headings: AUTHORS, CORRESPONDENCE, DEATHS, EDITORIALS, INDUSTRIAL HEALTH, MARRIAGES, MEDICAL ECONOMICS, MEDICO-LEGAL BRIEFS, NEWS OF THE STATE, ORIGINAL ARTICLES, PHYSICAL MEDICINE ABSTRACTS, STATE DEPARTMENT OF PUBLIC HEALTH.

Authors

A

Amatruda, Catherine S., 251
Ariel, Irving M., 361
Armstrong, Paul G., Col., 83, 213

B

Baba, G. R., 99
Bates, Faye E., 361
Bell, Julius N., 119
Bilek, George, 374
Bedinger, Paul L., 351

C

Calkins, L. A., 231
Castberg, H. T., 195
Coheen, Jack, 366
Conner, Arthur C., 161
Cross, Roland R., 340
Curtis, George M., 161

D

Davis, Ernest E., 103

F

Fahlstrom, Stanley, 76
Falls, Frederick H., 167
Fomon, Samuel, 242

G

Goodrich, Ben E., 317

H

Hall, Clifton, 369
Hoffman, Wm., 235
Hoopes, Benjamin F., 192
Hoyne, Archibald L., 295
Hughes, J. R., 235
Hutton, James H., 176

J

Johnson, Allen S., 2
Johnson, G. E., 374
Josephy, Herman, 107

K

Kirsner, Joseph B., 357
Kagen, Marvin S., 308
Kretschmer, Herman L., 171

L

Levinson, Abraham, 227
Limarzi, Louis R., 351
Lueth, Harold C., 93

M

McEnery, E. T., 99
McNealy, Raymond W., 315
Meyer, Esther, 308

N

Neuer, Hans, 255

O

Olsen, C. W., 374

P

Palmer, Walter Lincoln, 357
Patton, Charles L., 184
Patton, Robert J., 184
Peffer, J. R., 235

R

Rypins, Edwin L., 372

S

Sarrelangue, Luis Pavon, 322
Slobe, Frederick W., 71
Smith, Durand, 315
Sweany, Henry C., 189
Swenson, Roy E., 161
Syracuse, Victor R., 242

T

Togasaki, K., 99

V

Volini, Italo F., 235

W

Wellmann, G. O., 180
Werelius, Carl, 306
Winston, Burton J., 261
Woltman, Henry W., 299

Correspondence

A.C.S. Clinical Congress to be in Los Angeles 92
Active Duty Billets 158
Allergy at N. U., Orientation Course in, ... 91
American Goiter Association to Meet in Madison ..348
Auxiliaries in Illinois, Organization of, ...224
Bureau of Medicine and Surgery News 11
Chest Physicians Elect Officers 157
Civilian Resident Program, Vacancies Under, ...290
Clinical Conference, Annual 350
Crerar is Largest Medical Library in the Midwest .349
Crippled Children's Division Lists Clinics 289
Crippled Children's Division Lists January Clinics .349
Dermatologists to Meet in Chicago, Dec. 4-9 291
EMIC Program, Payment Under the, ...226
Endocrinology, Graduate Course in, ...157
Examiners May Earn Retirement Credit 350
Illinois National Guard Medical Department Letter 224
Illinois National Guard Medical Department, Reorganization of the, ... 9
Medical Care Fee Schedule, ...291
Medicolegal Problems, Symposium on, ...292
Mental Hospitals, "Method of Admission", Your, ..347
Mental Hospitals, Your, ...288
Mental Hygiene Section Sought, ...158
Michigan's Annual Meeting, Invitation to, ...158
Mississippi Valley Medical Society Meeting at Springfield 92
Naval Air Reserve Needs Doctors 158
Navy's New Medical Training Program 9
Obstetricians will Meet in Denver 92
Obstetrics and Gynecology, Refresher Course in, .. 8
Ophthalmologists, Tests for, ...226
Physical Medicine, The American Congress of, ... 91
Post Graduate Courses, The Chicago Medical Society, ... 8
Radio, New Health Series on, ... 290
Sale of U.S. Savings Bonds in Illinois 350
Saunders Appointed Associate Director 91
Siliform Ampuls Potentially Dangerous 157
Syphilis Records of Army Personnel Available 11
Urology, Prizes for Research in, ...226
Van Meter Prize Award, Announcement of, ...226
Warns of Danger in Distributed Solution 290
Woman's Auxiliary 159

Deaths

Abel, Theodore C. F. 387
Agnew, Theodore Lee 79
Aszmann, Arthur Max 274
Bachelle, Cecil V. 334
Bass, Jewell Lee 145
Bergeron, Eugene D. 145
Bertaut, Clarence J. 334
Beverly, Bert Ira 234
Boyne, Walter William 145
Briney, William Farmer 145
Burke, Alexander Walter 205
Christenson, John A. 334
Coffey, D. Fletcher 145
Cole, Charles Edward 79
Collins, Helen E. 334
Conway, Bernard P. 388
Crotty, William John 79
De Bey, Cornelia B. 205
Dodd, Frank Clark 79
Donaldson, Henry Bardwell 205
Donovan, Michael F. J., ...334
Dorris, Nettie Austin M. 388
Draper, Otto Granville 79
Dyer, Robert Edward 388
Eastman, Herbert Clinton 145
Eckman, John Wesley 79
Emerson, Edward Paul 274
Eddy, Warner Leaming 145
Enlow, Harry R. 334
Erlanger, Erich R. 334
Farthing, Edgar W. 334
Fox, Frederick B. 205
Galloway, Charles R. 334
Gibbs, William Walden 145
Gindele, George William 146
Green, Edgar Agassiz 205
Gronwold, Arthur C. 388
Hansen, Arthur R. 334
Hall, Alonzo 388
Harnagel, Frederick Henry 79
Hartfield, Ernest Monroe 334
Hinn, George Jacob 274
Hofman, Henry 146
Holmes, Edward Marcellus 205
Howard, Irwin Wilson 274
Hyslop, Orton Charles 205
Isenhart, Lawrence Francis 146
James, Matthew William 334
Johnson, Lyford McChesney 80
Johnson, Stanley Frederick 205
Johnson, Wilbur Vogt 388
Jones, Thomas Alfred 205
Jones, Thomas Alfred 388
Keene, Warren Walker 205
Klumpner, George 146
McGinnis, Philip Daniel 274
McGuiggan, John Edward 274
McKim, John Virgil 80
McNeill, Samuel Johnston 146
Mackey, Arthur N. 146
Magill, Clark R. William 146
Meloy, John Earle 274
Martin, Albert Rankin 388
Merritt, Nina Polson 80
Morgan, Thomas 80
Moss, Harry Corwin 205
Murray, Warren G. 388
Novak Jr., Frank J. 205-334
Nothinberg, Oscar J. 388
O'Connor, Thomas Philip 205
Osborne, Ray Randle 388
Otten, Harry 146

Pettitt, Herbert LeRoy 80
Phillips, John Ezra 80
Preble, Robert Bruce 274
Prescott, Eva 80
Raman, Henry Benjamin 334
Reynolds, Gardner Shaw 388
Riccio, Eugene A. 334
Ring, Frances A. 275
Ronayne, Frank Joseph 205
Ross, Percy J. 334
Rotman, David B. 80
Rydin, Carl Gustaf 275
Rypins, Edwin Louis 205
Saruk, Fred Seymour 205
Schoon, Theodore 146
Schram, Abraham W. 275
Shurtz, Straut Watson 334
Smith, Hiram Jason 205
Smith, William E. 146
Smith, William Lester 80
Spierling, Herbert F. 146
Steele, Henry Danford 146
Stotz, Charles Frederick 205
Stricker, Clifford John 205
Taylor, Richard Wade 275
Tetrev, Henry 388
Thompson, John R. 80
Thompson, Orris Martin 334
Thomas, Wesley Munger 388
Treadway, Ollie Herbert 275
Tuck, William Osgood 275
Urheim, Jacob L. 146
Volini, Camillo Eugene 146
Voorheis, Charles Henry 80
Walton, John Edward 80
Washborn, George Ulysses 205
White, Ernest C. 388
Weishew, Louis Jerome 146
Wilcox, Bert G. 388
West, John H. 80
Whipple, Walter B. 80
Winkler, Oliver Benjamin 334
Williamson, Earl W. 80
Yates, Frederick H. 275
Wolf, Benzion 388
Young, James McClain 388
Zohrlaut, George Guido 275

Editorials

Abt, Dr. Isaac A., Received Distinguished Service Award, ... 82
Annual Meeting of the American Medical Association [illegible] 1948, ... 81
Book Reviews, July 52, Aug. 50, Sept. 54, Oct. 60, Nov. 56, Dec. 56.
Cancer Diagnostic Clinics, State Aided, ... 5
Cancer Symposium is Fo. You 339
Chicago Medical School, Full Approval Given to, .337
Council Meeting Minutes, August 29, 1948, 263, & November 7, 1948 376
Dedication 213
Diabetics Detection, The Physician in, ... 283
Dues Have Been Raised, Your, ... 211
Evans, Death of Dr. William A., ... 338
General Practitioner, The 209
General Practitioner, Selecting The Outstanding, ..149
History of Medicine in Illinois 150
Hospital Construction in Illinois Downstate Areas .211
House of Delegates, (First Session, May 10, 1948) . 14
House Of Delegates (Second Session, May 12, 1948) 121
House of Delegates, Transactions of the, ... 1
Hoyt Named Illinois' Top G.P. for 1948 277
Interim Session of the American Medical Association, The, ... 150
Journal Awards are Presented, 1947-1948 278
Medicine's Frankenstein Monster (Johnson) 2
Nation's Health; A Ten Year Program, "The, ... 280
Physician and Veteran Groups, The, (Armstrong) . 83
Pictorial Report on the 1948 Annual Meeting 113
Physicians for the Army 281
"Politicians, M.D." 338
Report of the Committee on Immunization 4
Selective Service Act, Medical Examination Procedure Under 1948 213
Students Receive Joint ISMS-IAA Loans for Training, First Medical, ... 282
World Medical Association 1

Industrial Health

Light Work (Slobe) 71
Occupational Disease in Differential Diagnosis, (Castberg) 195

Marriages

Dame, Robert Lowell 387
Elghammer, W. Robert 387
Graff, Richard J. 274
Guinan, Mark C. 387
Scholer, Henry C. 387

Medical Economics

Economic Significance of Pre-Employment Examinations 12
Gene, The Mighty, ... 285
Pathologist in Group and Hospital Practice, The, .215
Postmortems 343
Pre-Marital Tests and Marriage Counseling 153
Vacations 89

Medico-Legal Briefs

Liability in Operations to Produce Sterility, Possible, ... 217

News of State

Coming Meetings, Personals, Marriages, Deaths 73, 137, 199, 268, 325, 379

Original Articles

Appendiceal Lithiasis, Case Report, (Hoopes) 192
Atomic Age, Problems of Medical Care in the, (Lueth) 93
Cancer, Delay in Treatment of, (Bates & Ariel) ..361
Cancer of The Large Bowel, Unnecessary Rectal Operations Done in the Presence of, (McNealy & Smith) 315
Cancer, Progress in, (Kretschmer) 171
Chest Diseases, Diagnosis of Chronic, (Sweany & Thompson) 189
Cholecystenterostomy, New Method of, (Werelius) 306
Cholesterol-Basal Metabolism Determinations — Clinical Observations in 830 Cases, (Hutton & Fahlstrom) 176
Endocarditis Treated with Streptomycin, Case Report, Subacute Bacterial, (Bell) 119
Hyperthyroidism, Propyl Thiouracil in The Management of Complicated, (Curtis, Connor & Swenson) 161
Labor, The Management of, (Calkins) 231
Lobotomy, Follow-Up Studies of Patients with Pre-Frontal Lobe, (Coheen) 366
Malignancies of the Small Intestines, Roentgen Ray Aspects of, (Rypins) 372
Meningitis, Treatment of Influenzal, (Levinson) ..227
Meningitis, Intrathecal Therapy Contraindicated for, (Hoyne) 295
Mental Deficiency, The Constitutional Emotional and Cultural Factors Producing, (Neuer) 255
Miniature Films, Mass X-Ray Examination Using, (Hall) 369
Mycotic Infections in Illinois, Deep, (Meyer & Kagen) 308
Neostigmine Therapy, Additional Observations in, (Winston) 261
Obstetrics, Conservative, (Davis) 103
Ovarian Thecoma: Case Reports with Constrasting Symptomatology, (Patton & Patton) 184
Pediatrics, The Role of Developmental Diagnosis in, (Amatruda) 251
Penicillin, Studies in the Oral Administration of, (Volini, Hoffman, Hughes & Peffer) 235
Peptic Ulcer, The Present Management of, (Kirsner & Palmer) 357
Phenylpyruvic Oligophrenia, (Josephy) 107
Placenta Previa, The Surgical Aspects of, (Falls) 167
Poliomyelitis, The Differential Diagnosis of, (Woltman) 299
Precocious Puberty in a Three Year Old Girl, Case Report (Pavon) 322
Respiratory Infections, The Direct and Indirect Therapy of Acute, (Goodrich) 317
RH Factor, the Clinical Application of the, (Baba & Togasaki) 99
Rhinoplasty, Routine Technic of a Typical, (Fomon & Syracuse) 242
Sternal Puncture, The Clinical Interpretation of, (Bedinger & Limarzi) 351
Thrombophlebitis and Phlebothrombosis (Wellmann) 180
Toothpick in Ascending Colon, Case Report, (Olsen, Johnson & Bilek) 374

Physical Medicine Abstracts

Physical Medicine Abstracts .. July 40, Aug., 40, ... Sept. 42, Oct. 44, Nov. 44, Dec. 44

State Department of Public Health

Dental Caries, Program for Prevention of, ...293
Disasters Without Disease 155
Hospital Survey and Construction Plan in Illinois Gets Under Way 84
Maternal Death Rate in Illinois, The Course of the, 219
Mt. Vernon, State Tuberculosis Sanatorium, (Cross) 340

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The ILLINOIS Medical Journal

VOL. 94 NO. 1

July, 1948

First Session of The House of Delegates

Economic Significance of Pre-Employment Examinations

(See page 31 for complete Table of Contents)

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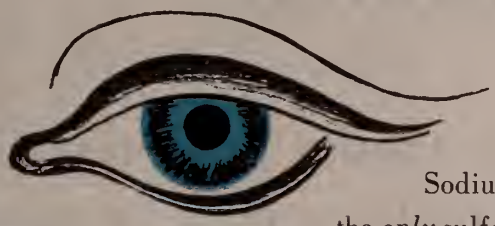
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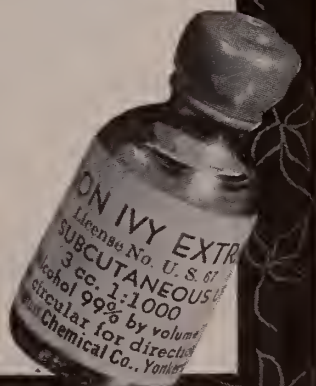
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**Krasno, L., Karp, M., and Rhoads, P. S., (1948), Inhalation of Dust Penicillin, Ann. Int. Med., 28: 607-617, March.*



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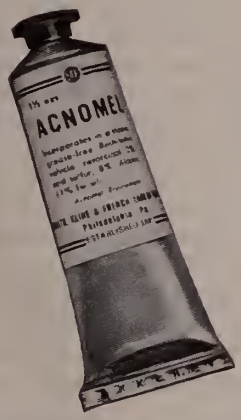
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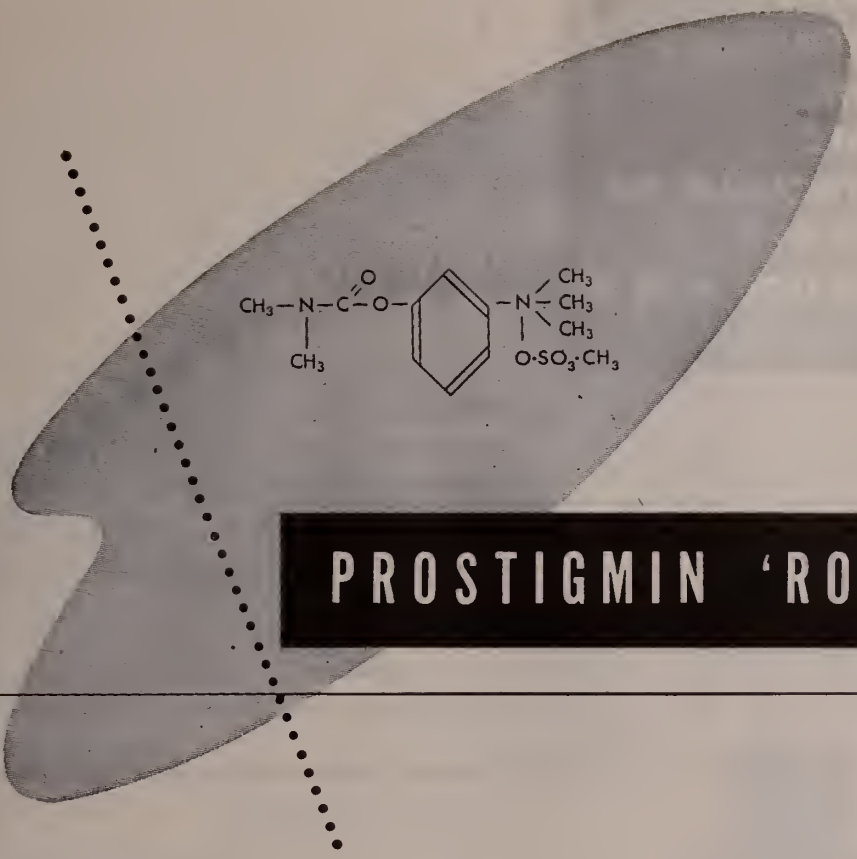


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REFERENCES
1. Jones, B. B.: Virginia Med. Monthly, 74:241, June, 1947.
2. Levine, S. Z.: J. A. M. A., 128:283, May 26, 1945.
3. Schroeder, L. J. et al: J. Nutrition, 32:413, Oct., 1946.



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References: 1. Gold, Harry: In Conferences on Therapy, N. Y. State J. of Med., Mar. 1, 1947. 2. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., New York, 1941. 3. Osol, A. and Farrar, G. E.: Dispensatory of U.S.A., J. B. Lippincott Co., Philadelphia, 24th ed., 1947. 4. Sollmann, T.: A Manual of Pharmacology, W. B. Saunders Co., Philadelphia, 7th ed., 1948. 5. Loc. cit., p. 750.

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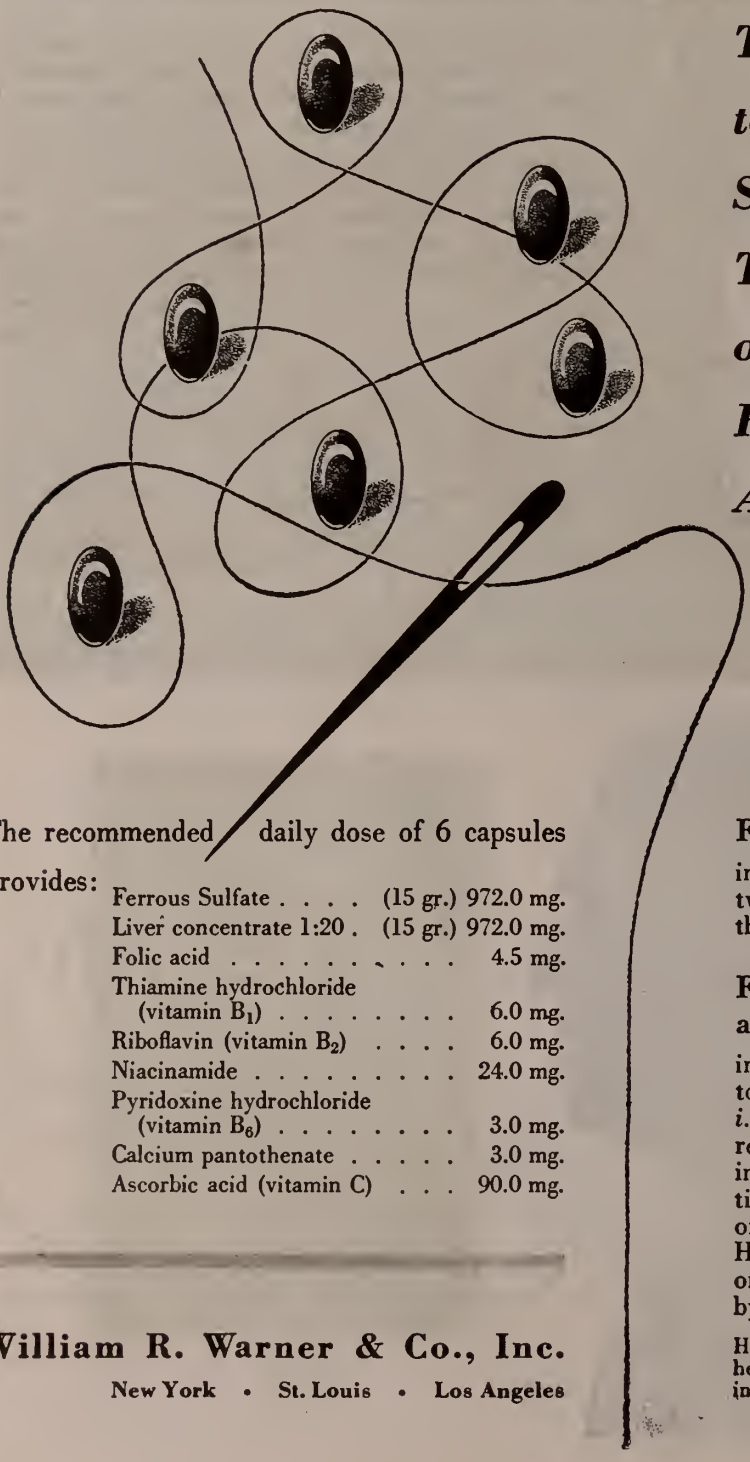
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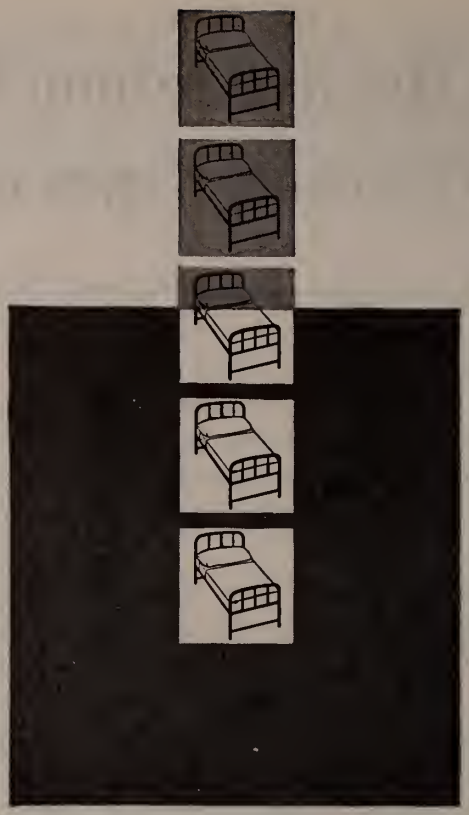
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1. Pierce, R. R.: Am. J. Obst. & Gynec. vol. 55 (Feb.) 1948.

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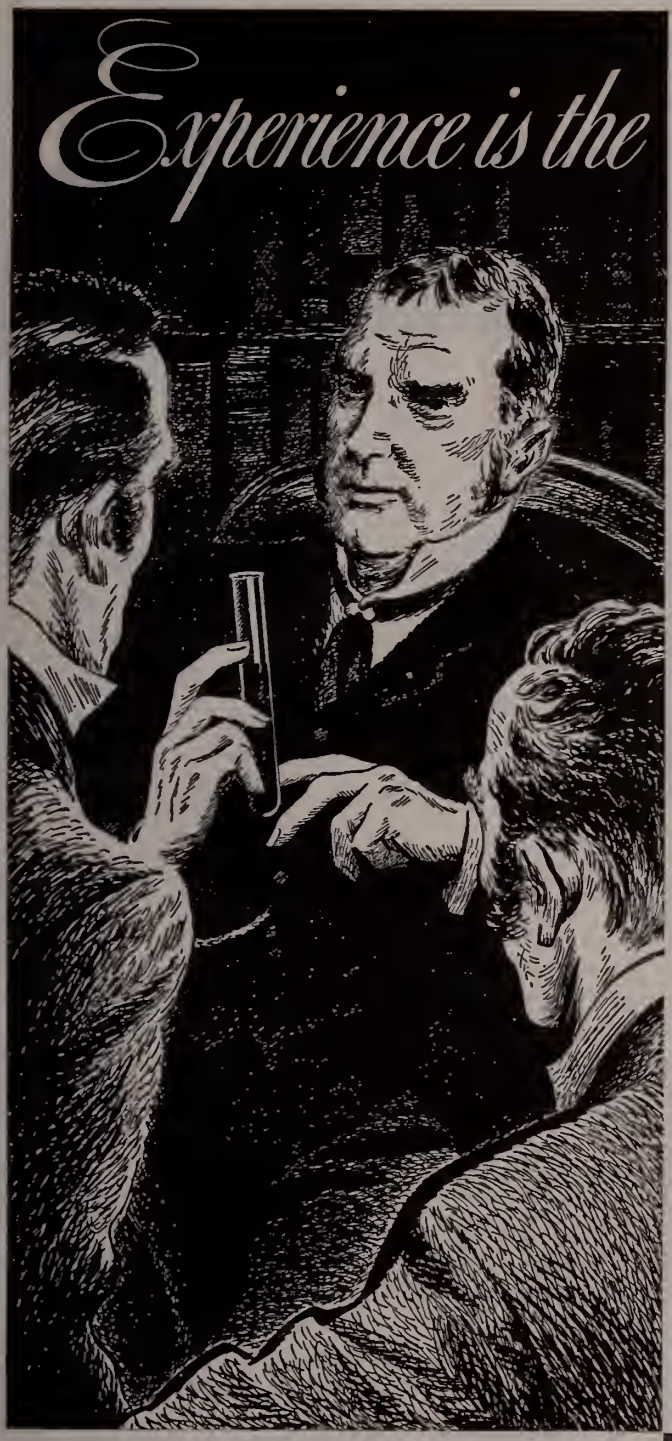
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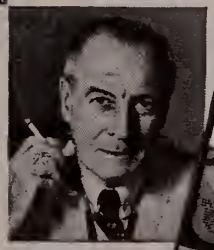
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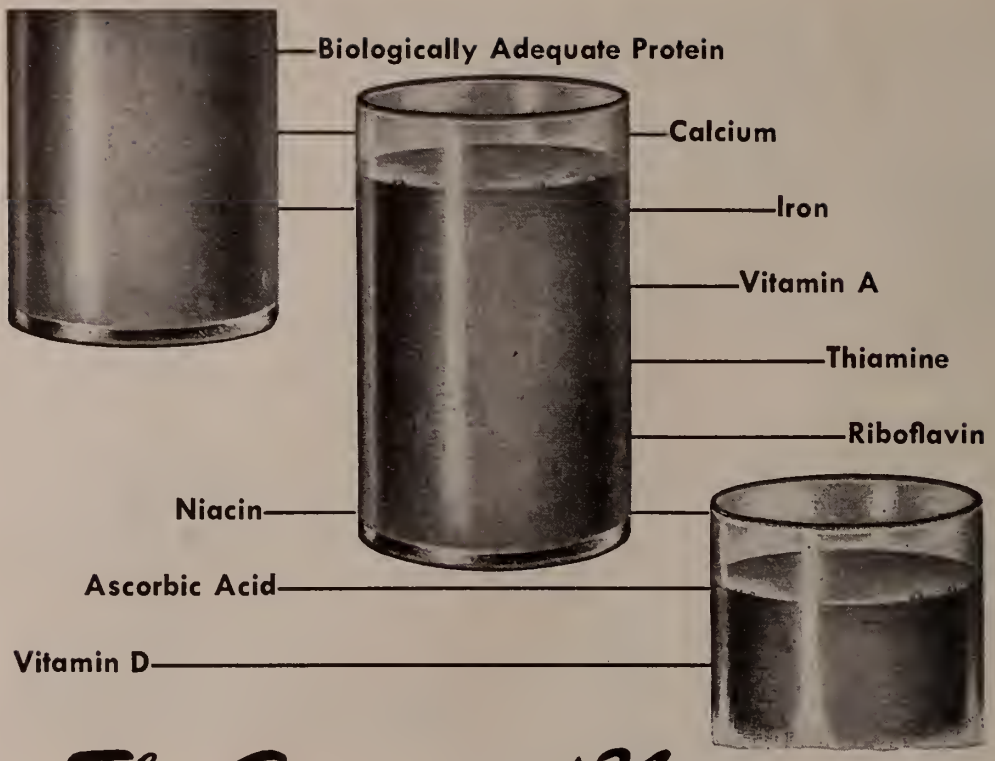
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BIBLIOGRAPHY (1) De Lee, J. B. and Greenhill, J. P. Principles and Practice of Obstetrics, Saunders, Philadelphia, 1947, p. 95. (2) Bicknell, F. and Prescott, F.: The Vitamins in Medicine, Grune and Stratton, New York, 1947, p. 663, p. 189, p. 326.

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1. Frant, S., and Abrahamson, H.: *Brennemann's Practice of Pediatrics*, *1*:28:22, 1945.
2. Blattner, R. J.: *J. Pediatrics*, *32*:220, February, 1948.

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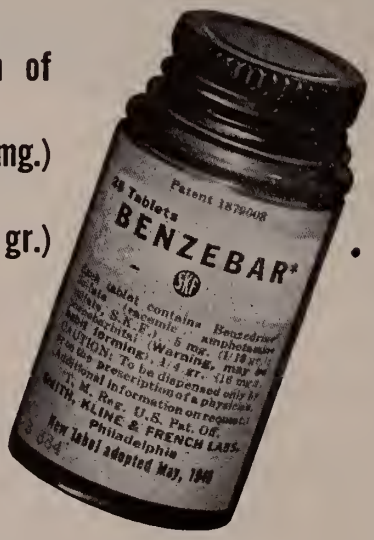
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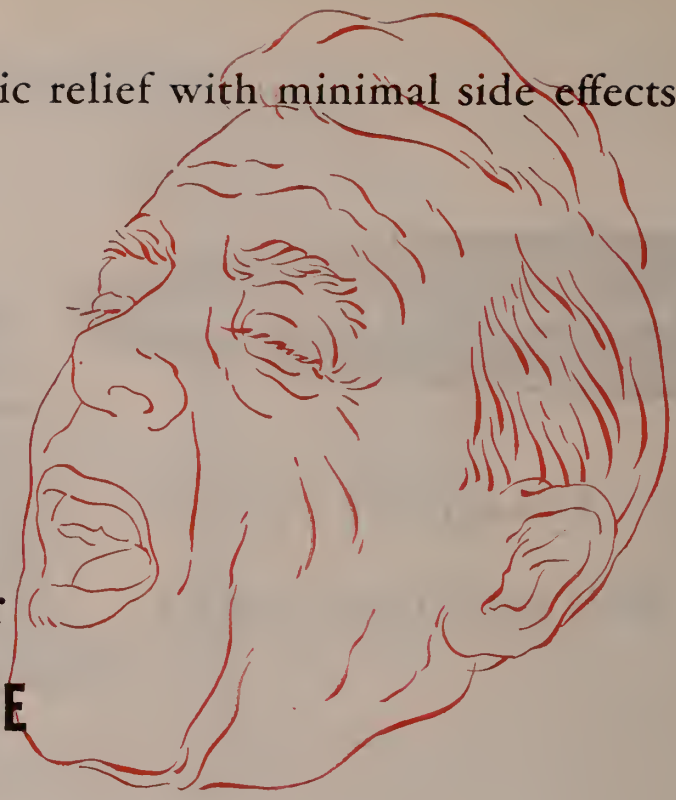
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Vitamin B_2	6.0 mg
Vitomin B_6	3.0 mg
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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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TABLE OF CONTENTS

JULY, 1948
Vol. 94, No. 1

HOUSE OF DELEGATES
First Session, May 10, 1948 14

EDITORIALS
Transactions of the House of Delegates 1
World Medical Association 1
Medicine's Frankenstein Monster, *Allen S. Johnson, M.D.*, Springfield, Massachusetts 2
Report of the Committee on Immunization 4
State Aided Cancer Diagnostic Clinics 5
Book Reviews 52

CORRESPONDENCE
The Chicago Medical Society Post Graduate Courses 8
Refresher Course in Obstetrics and Gynecology .. 8
Navy's New Medical Training Program 9
Reorganization of the Illinois National Guard Medical Department 9
Syphilis Records of Army Personnel Available 11
Bureau of Medicine and Surgery News 11

MEDICAL ECONOMICS
Economic Significance of Pre-Employment Examinations 12

INDUSTRIAL HEALTH
Light Work, *Frederick W. Slove, M.D.*, Chicago .. 71

PHYSICAL MEDICINE ABSTRACTS 40

NEWS OF THE STATE 73

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A 15 x 12 reproduction of this Francis Chase illustration is available upon request.

MORE than any other Latin-American country, Argentina resembles the United States in climate, industries, and educational system. Although Argentina produces a large share of her own industrial and agricultural requirements, a mutually profitable trade has developed between the two countries.

The first Lilly medical service representative in Argentina began his calls on physicians and pharmacists in 1931. In 1944, Eli Lilly and Company of Argentina, Inc., was formed. Today, over 13,000 physicians are visited regularly. All medical literature, including the *Physician's Bulletin,* is printed in Spanish. Cordial relations of long standing exist between the men engaged in medical research and Eli Lilly and Company. The facilities of the Lilly Research Laboratories are always available for collaboration on mutually interesting projects. The beneficiaries of medical research are all peoples everywhere.



The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 1 July, 1948

TRANSACTIONS OF THE HOUSE OF DELEGATES

In accordance with the usual custom, the minutes of the first meeting of the House of Delegates, in connection with the 1948 annual meeting, held May 10-12 in Chicago, are published in this issue of the *Illinois Medical Journal.*

The annual reports, as printed in the hand books with some supplementary reports given to the House, constitute the major portion of the minutes of this first meeting. Much factual data concerning the activities of the State Society as a whole, through its officers, council and various committees, will be found in these reports, and it is hoped that the membership of the Society as a whole will read these reports carefully.

These reports were referred to the usual reference committees for study and subsequent report, members of the House and other members being permitted to go before the committees to discuss reports and other matters referred to the committees for consideration.

At the second meeting of the House of Delegates, the reference committees gave their reports, which were acted upon by the House as a whole. Many items of new business, resolutions, etc., were acted upon, and this session will constitute the second portion of the transactions to be published in the August issue of the Journal.

These transactions are published each year to show the membership of the Society what their House of Delegates has done, and makes a permanent record of the transactions. Prior to the publication of the *Illinois Medical Journal,* the Society each year published bound volumes of the transactions, as well as some of the addresses presented at the annual meetings, these dating back to 1850, when the reorganization meeting was held. They were published annuallly until 1899, when the *Illinois Medical Journal* first made its appearance.

It is hoped that the membership of the Society will read these transactions and be better informed as to what is being done by their elected representatives.

WORLD MEDICAL ASSOCIATION

The World Medical Association was organized in Paris, in September, 1947, with representatives from many nations present. It seemed highly desirable to promote friendly relationship between the national medical organizations of the various countries. The American Medical Association was officially represented at this organization meeting, which had been approved by the A. M. A. House of Delegates.

The governing Council held a meeting in New York, April 26-29, and Louis H. Bauer, Hempstead, New York, who formerly was a member of the Council, was made Secretary-General of the Association. Doctor Bauer is a member of the Board of Trustees of the A. M. A., a past president of the Medical Society of the State of New York, and has been very active in medical and organization affairs over a long period of time, and this signal honor recently given him is most appropriate indeed.

Elmer L. Henderson, Louisville, Kentucky, was elected as a member of the Council to replace Doctor Bauer. Doctor Henderson is Chairman of the Board of Trustees of the American Medical Association, and he too has long been interested in the many problems of the medical profession, and has been active in the affairs of his State Medical Society and the A. M. A.

On the evening of April 30, the Illinois State Medical Society and the Chicago Medical Society jointly sponsored a dinner for representatives of the World Medical Association who were visiting in Chicago. Representatives from a number of foreign countries, including the President of the World Medical Association, Prof. E. Marquis, of France, were present.

Other honored guests present at the dinner were: T. C. Routly, Canada, Chairman, D. Knutson, Sweden, Vice-Chairman, Louis H. Bauer, U. S. A., Jose A. Bustamante, Cuba, Paul Cibrie, France, Alexander Hartwick, Austria, P. Z. King, China, J. A. Pridham, Great Britain, S. C. Sen, India, L. G. Tornel, Spain, Charles Hill, London, England, Secretary, J. Stuchlik, Czechoslovakia, President-Elect and O. Leuch, Switzerland, Treasurer.

Prof. Marquis in an interesting address told how amazed they were to see such hospitals and medical educational intitutions as we have in the United States.

They likewise marvelled at the work and growth of the American Medical Association and our State Medical Societies. He stated frankly that in many other countries the medical profession is under state control, while in this great country the medical profession has built up and run their gigantic organizations without any outside help. This same expression was given during the evening by other representatives.

Irving H. Neece, as President of the Illinois State Medical Society, and Warren W. Furey, as President of the Chicago Medical Society, gave the official welcome for their respective societies to the distinguished guests from a number of foreign nations. Doctor Furey acted as toastmaster on the occasion and as usual presided in a most interesting manner. He called upon many of the distinguished guests present for a few informal remarks, all of which were most interesting indeed.

We, in this country, where our work is not supervised by political units, should ever realize the freedom and democracy which is ours. We should likewise thoroughly realize the dangers before us, and conduct ourselves in the usual routine so that we shall not be criticized on the part of those who believe our work should be thoroughly subsidized, and that only through federal control can modern medicine be practiced in the future. By getting direct information from physicians practicing in those countries which have a National Health Insurance Plan, as to their own limitations, and the many restrictions which they encounter in their daily endeavors, we should do everything possible to retain American medicine as a purely private enterprise.

GUEST EDITORIAL

MEDICINE'S FRANKENSTEIN MONSTER —

Allen S. Johnson, M.D.
Springfield, Massachusetts

There often appears to be a conflict between the remedies for the solution of our social problems. The politician is accused of myopia because he concerns himself with the immediate needs of his constituents. The economist is branded as visionary and utopian because he hopes to obtain ultimate benefits for society by the long range adjustment of economic forces. The doctor is in much the same plight as the politician. His immediate concern is to satisfy his patient and, if possible, to benefit him. That the recovery of the patient is of benefit to society is implicit in the practice of medicine. But it is occasionally worth while to shift from the oil immersion lens focussed on the problems of the individual to the low power objective that views him in relation to his group and to the survival of this group as a societal entity. Is our humanitarian concern with the problems of the in-

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Original articles and membership correspondence to Dr. Harold M. Camp, Monmouth, Ill.

Society proceedings and news items and changes in the mailing list to Managing Editor, 30 N. Michigan Ave., Chicago 2, Illinois.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $3.00 per year, in advance, postage prepaid, for the United States, Cuba, Porto Rico, Philippine Islands, Hawaiian Islands and Mexico. $4.00 per year for all foreign countries included in the postal union. Canada, $3.50. Single current copies, 50 cents. By mail, 60 cents.

dividual distracting us from measures that are essential to the ultimate survival of the group? Are our humanitarian institutions taxing our energies for the protection of the unfit to the neglect of the more desirable strains of protoplasm on which our ultimate economic and biological survival must depend?

It has been remarked that "It is an interesting commentary on our social organization that two antithetical forces like war and humanitarian institutions should protect the unfit at the expense of the fit. Yet we stage a war every twenty-five years and demand that only the physically fit and psychologically well adjusted be allowed the privilege of dying for their country. The unfit are protected to perpetuate the race. The inadequate personality is sustained inside and outside of institutions by a variety of Federal, State and Municipal agencies. Even an indisposition to work seldom results in starvation. The unfit is not wanted by the Selective Service Board and even if he leaks thru its wide meshed screen and withstands the imprecations of his superiors he seldom is assigned to dangerous or fatal duty because he is incompetent and irresponsible. He may be shorn of prestige and

material goods but his voting and procreative powers remain unimpaired and he and his multitudinous offspring bid fair to be with us always and in ever increasing numbers."[1] The extent to which the unfit are protected at the expense of the fit is illustrated by the annual cost of their institutional care compared with the total expenditures of the Department of Public Health in Massachusetts. In 1946 the total cost of caring for mental, epileptic, and feeble-minded patients was approximately 14 million dollars. The total expenditures of the Massachusetts Department of Public Health for the latest year available, ending in 1944, was less than 2½ million dollars. The total amount spent by the state and its municipalities for public education in a recent fiscal year was about $81,700,000. During the year that Massachusetts feeble-minded, insane, and epileptic patients cost the taxpayer 14 million dollars they occupied 50% of all the hospital beds and constituted 56% of the daily patient treatment load of all types of patients in Massachusetts hospitals. Comparable figures for the country as a whole are not available but they may be inferred from the fact that during the same year the hospitals for nervous and mental disease had 46% of all hospital beds and the general hospitals only 43.7%. During this period the former provided 232,055,685 treatment days or 51.3% of the daily patient load compared to 181,232,355 treatment days given by the general hospitals. Were these vast expenditures of time, space, money, and energy accomplishing significant rehabilitation of the beneficiaries, the ultimate outlook would be less discouraging. But much of the expenditure in the field of nervous and mental disease today is allocated to mere custodial care. Nor is there much hope of rehabilitating the mentally deficient who constitute such a large part of this load. The magnitude of the problem is further illustrated by Selective Service Board rejections during the last 18 months of the recent war. Forty-four percent of the examinees were rejected. Of these rejections 26.8% were for mental disease; 2.6% for mental deficiency; 12.8% for subminimal intelligence.

If we add to these figures the number of people in penal institutions the burden on society appears staggering. In 1946, 18,698 prisoners were confined in federal institutions and approximately 118,000 in state penal institutions. Meninger[2] has stated that "The cost of crime to the American public was estimated to be between 10 and 18 billion dollars a year to operate 147 federal and state penal institutions." Over and beyond this is the incalculable burden of county and municipal populations. Nor is the prospect for rehabilitation of our prison population encouraging inasmuch as the studies of the Gluecks[3] have shown that 80% of them will become recidivists.

Yet these misfits are protected inside or outside institutions to sire the next generation while the most promising biological strains are sacrificed in each war to protect them. The day may be not far distant when we shall have to decide whether the unbridled fecundity of this growing horde of poor protoplasm is to be allowed to drive society into economic and biological bankruptcy.

REFERENCES

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2. Menninger, W. C., Bulletin of the Menninger Clinic, January, 1948.
3. Glueck, S. and E. "Five Hundred Criminal Careers".

REPORT OF THE COMMITTEE ON IMMUNIZATION*

Active Immunization —

When immunization against diphtheria, tetanus and pertussis is attemped before the sixth month of life, only siow absorbing antigens alum-precipited, aluminum hydroxide, etc.) are recommended. The dosage recommended by the manufacturer of the material used should be followed. To avoid severe local reaction, each dose is injected into the deeper tissues of alternate lateral upper arms or alternate lateral gluteal areas. Each dose is terminated with approximately 0.1 cc. air. Prompt massage over the needle site prevents seepage. Care is exercised to avoid the site of a previous dose, and to avoid intravenous injection.

Three alternatives are available (see Immunization Schedule).

Smallpox vaccination may be done at any time after the first week of life, preferably before the first birthday. Vaccination should be repeated until a primary take occurs, because one should not assume that there is a natural immunity. It should not be done during hot weather, or when there is generalized eczema, or other generalized skin eruption. An immune reaction (local

*Chicago Pediatric Society

SCHEDULE OF ACTIVE IMMUNIZATION (THREE AVAILABLE ALTERNATIVES)

	A	B	C**
3 mos.	Triple Antigen (slow absorbing)*	Pertussis Vaccine (slow absorbing)	
4 mos.	Do	Do	
5 mos.	Do	Do	
6 mos.	Do	Do	Triple Antigen** (fluid or slow absorbing)
7 mos.	Smallpox Vaccination	Diphtheria and Tetanus Antigens (fluid or slow absorbing)	Do
8 mos.		Do	Do
9 mos.		Do	
10 to 12 mos.		Smallpox Vaccination	Smallpox Vaccination
2 yrs.	Booster Dose Triple Antigen (fluid or slow absorbing)	Better Dose Triple Antigen (fluid or slow absorbing)	Booster Dose Triple Antigen (fluid or slow absorbing)
5 yrs.	Do	Do	Do

A booster dose or smallpox revaccination is recommended when a previously immunized child is presumably exposed to these diseases.

* Antigens that have been so modified as to be slow absorbing (e.g., alum-precipitated, aluminum hydroxide, etc.).

** Starting at 6 months of age or later, monthly doses of the antigens (fluid or slow absorbing), giving them singly or in combinations—as Diphtheria-Pertussis, Diphtheria-Tetanus, or Diphtheria-Tetanus-Pertussis.

redness for 24 to 48 hours, no vesicle) or an accelerated reaction (small pustule within 3 days) can occur only in a previously vaccinated individual. Revaccination is recommended at six and twelve years of age.

Primary immunization against scarlet fever, typhoid fever, tick fever, etc., may be given when indicated. A booster dose or reimmunization in this group should be given as recommended by the manufacture of the material used.

A routine booster dose of triple antigen (fluid or slow absorbing diphtheria-tetanus pertussis) is recommended in the previously immunized at about the ages of two and five years. A booster dose (fluid or slow absorbing) is recommended promply following presumed exposure of the previously immunized.

Passive Immunization

Diphtheria — Antitoxin (10,000 units) in known exposure of the nonimmunized.

Measles — Human Immune Serum Globulin is recommended for modification or prevention when indicated. The dosage recommended by the manufacturer of the material used should be followed.

Pertussis — Human Pertussis Hyperimmune Serum (20 cc.) or Human Hyperimmune Globulin (2.5 cc.) promptly when indicated, i.e., in known exposure of nonimmunized infant or frail child. For treatment, repeated doses are recommended as necessary.

Tetanus — Antitoxin (5,000 units) is promptly administered in the nonimmunized after an injury that might lead to tetanus infection. Subsequent immunization with tetanus toxoid is recommended.

STATE AIDED CANCER DIAGNOSTIC CLINICS

I. General Policies

1. Before State-aided cancer clinic can be established, the project must be approved by the County Medical Society of the County in which the clinic is located. In addition to approving the establishment of the clinic, the County Medical Society must guarantee that its members will support the activities of the clinic.
2. Cancer Diagnostic Clinics are preferably located in hospitals although this is not absolute-

ly necessary. The setting up of clinics outside of hospitals, however, is discouraged and the reasons are apparent. The establishment of a clinic in a hospital necessitates full approval of the medical staff and the administrative staff. Futhermore, the medical staff must guarantee its full support to the operation of the clinic.

3. In the organization and operation of such clinics the standards of the American College of Surgeons should be met as nearly as possible and practicable.
4. The Division of Cancer Control of the Illinois Department of Public Health aids in the promotion of such clinic, provides funds for their establishment and operation and exercise reasonable supervision. The actual clinical and administrative operation of the clinic, however, is in direct charge of the cancer clinic staff appointed by the staff of the hospital in which the clinic is located. The business affairs of the clinic are handled through the business office of the hospital.

II. Objectives:

1. To provide a competent consultation service for physicians and dentists in the early diagnosis of cancer.
2. To provide without charge, all approved modern diagnostic facilities for patients who cannot afford to pay for this service.
3. To follow up cancer cases after diagnosis in order to determine if the patients have been treated, and to follow up cases after treatment in order to determine the result of such treatment in the survival period of the patients.
4. To collect, record and analyze pertinent statistical data regarding clinic cases particularly from the point of view of evaluating the success of the State-aided cancer program.

III. Clinical Procedure:

1. Patients are admitted to the clinic only through referral by their private physician.
2. The referring physician accompanies the patient and presents the case history and physician findings to the clinic.
3. When it is impossible for the referring physician to be present with his patient, a written statement including a brief history, x-ray findings, and other labortory reports, is sent to the Director of the clinic.
4. If the patient is unable to pay for diagnostic service, the reporting physician should so indicate to the Director of the Clinic.
5. While it is true that regular periods are set aside for the clinic sessions, nevertheless, in case a patient should be referred between regular sessions, provision is made for an examination by a member or members of the cancer clinic staff.
6. After the completion of consultation, the patient is directed back to the referring physician for final disposition. A written report, embodying the diagnosis and recommendations for treatment, by the clinic staff, is sent to the referring physician under the signature of the Director of the Clinic unless the physician is present at the session and receives the verbal report.

IV. Clinic Staff:

1. The basic staff must consist of a pathologist, radiologist, general surgeon and internist. This is in accordance with the standards established by the American College of Surgeons.
2. Appointments to the basic staff of the clinic should be made on a permanent basis. If the clinic is located in a hospital the appointment of such a staff follows the customary procedure of staff appointment as is followed in that hospital. If the clinic is not located in a hospital and is operated directly by the County Medical Society, then the clinic staff is appointed directly by the County Medical Society.
3. One of the basic staff is selected to serve in the capacity of Director of the clinic. The Director above all should be on a permanent basis.
4. If available, additional staff members representing the surgical specialties, dermatology, oral surgery and so forth, should be appointed. These staff members are more or less on call as needed, and do not have to be appointed on a permanent basis.
5. In communities where the clinic has been established in one hospital, and one or two other hospitals exist in that community, the clinic staff should be representive as far as practical of all of the hospitals.
6. In addition to the professional staff of the cancer clinic, there should be included a part-time or full-time medical secretary whose duties consist primarly of maintaining proper

records of clinical cases; the reports of such information as may be necessary to the Division of Cancer Control, Illinois Department of Health; the arranging of patient appointments for the clinic; and the follow-up of cases of cancer diagnosed at the clinic. For those clinics held in hospitals, a nurse is usually assigned by the hospital to assist in the handling of the patients. In those clinics held outside of hospitals, a nurse from the local health department serves in the same capacity as the afore-mentioned nurse.

V. Clinic Sessions:

1. The frequency of clinic sessions depends entirely upon the demand for such service in the community in which the clinic is located. It is always better to underestimate than to overestimate the potential patient load. In other words, it is better to start off conservatively with fewer good sessions than to attempt to hold mediocre sessions at more frequent intervals.
2. Where indicated it is always preferable that regular sessions be held each week. It is felt that regular sessions should be held no less than once a month. The various state-aided cancer clinics vary in this regard from clinic sessions meeting six times a week to those meeting once a month.
3. Three or four times a year more formal clinic sessions should be held at which selected cases of particular interest are presented and some outstanding authority in that field is invited to be present in the capacity of a teaching consultant.
4. In general it is preferable that notices of all clinic sessions be sent regularly by mail to physicians and dentists in local and adjacent communities. At first it may seem that little is accomplished by such a procedure, but over a long period, unquestionably those notices will result in greater participation by the physicians contacted in this matter.

VI. Charges To Patients:

1. All referred patients are admitted to the clinic without charge regardless of the patients' financial status. These patients receive the benefit of the clinic consultation.
2. When special diagnostic procedures are required, those patients able to afford it, are expected to pay for these services.
3. Patients who cannot afford to pay for diagnostic service are provided with all necessary diagnostic procedures without charge. The funds to provide for the payment of such services are made available through the Division of Cancer Control, Illinois Department of Public Health.
4. The patients inability to pay for service is determined from the certification to that effect by the referring physician, or by another authority acceptable to the Director of the Clinic.

VII. Pathological Diagnostic Service:

1. As part of its service each State-aided cancer diagnostic clinic makes available a pathological diagnostic service under the direction of a qualified pathologist.
2. Tissues suspected of malignancy may be brought or sent to the clinic's pathologist for examination. Containers for mailing such specimens are provided, upon request, by the Division of Cancer Control, Illinois Department of Public Health, Springfield, Ill.
3. This tissue diagnostic service is available for both physicians and dentists.
4. In the case of patients who cannot afford to pay for such service, if the physician or dentist submitting the tissue specimen, so certifies, no charge is made for this service. Funds to provide for free service of this sort are supplied by the Division of Cancer Control, Illinois Department of Public Health.
5. There is no restriction as to which clinic, tissue specimens should be submitted, and the physician and dentist concerned may select the clinic of his choice. It should be emphasized, however, that it is preferable for specimens to be sent to the nearest State-Aided Cancer Diagnostic Clinic because this results in a more even distribution of the tissue service and also expedites the pathological examination and report to the referring physician or dentist.
6. The accuracy and thoroughness with which the request form, accompanying a suspected malignant tissue, is filled out has a marked bearing on the diagnostic accuracy and completeness of the pathologist's examination and final report.

CORRESPONDENCE



THE CHICAGO MEDICAL SOCIETY POST GRADUATE COURSES

A post graduate course on hematology and neurology sponsored by the Chicago Medical Society will be held September 13th-18th. The faculty will be the following:

Howard L. Alt, Robert C. Bassett, F. H. Bethell, Benjamin Boshes, Paul C. Bucy, Stanley Cobb, William Dameshek, P. J. Fouts, George Guest, Clark W. Heath, R. W. Heinle, Raphael Isaacs, Edgar Jones, Walter R. Kirschbaum, Roy R. Kracke, Ben W. Lichenstein, Louis R. Limarzi, Roland P. Mackay, F. W. Madison, John Martin, Eric Oldberg, Lewis J. Pollock, A. J. Quick, E. H. Reinhard, Steven O. Schwartz, C. H. Watkins, Maxwell M. Wintrobe, B. K. Wiseman, John B. Youmans.

A course covering cardiovascular and respiratory diseases will be given the following week, September 20th-25th, with these doctors on the faculty:

Alfred W. Adson, J. B. Amberson, Charles P. Bailey, William H. Bunn, Russell L. Cecil, Geza de-Takats, Samuel M. Feinberg, Smith Freeman, Stanley Gibson, N. C. Gilbert, Jerome R. Head, Norris J. Heckel, Paul H. Holinger, Harry L. Huber, Louis N. Katz, Robert W. Keeton, T. J. Kinsella, T. C. Laipply, Karl P. Link, Gilbert H. Marquardt, Ovid O. Meyer, Francis D. Murphy, J. A. Myers, Irvine H. Page, Willis J. Potts, Paul S. Rhoads, F. R. Schemm, James P Simonds, William B. Wartman.

Both courses are limited to 100 and open to physicians in good standing in their local medical societies. The fee is $50.00 for each course.

For a copy of the program and application, write Dr. Willard O. Thompson, Chairman, Committee on Postgraduate Education, Chicago Medical Society, 30 North Michigan Ave. Chicago 2.

REFRESHER COURSE IN OBSTETRICS AND GYNECOLOGY

A one week Refresher Course in Obstetrics and Gynecology sponsored by the Illinois State Medical Society, the State Department of Public Health and the University of Illinois will be given at the Research and Educational Hospital beginning August 9th. It will consist of formal lectures, clinical conferences, round table discussions, manikin demonstrations, ward walks and out-patient clinics. The staff of the Research and Educational Hospital plus invited lecturers from Northwestern University, Loyola University and University of Chicago will give the course. The program will occupy the time from 9 to 5 daily.

The course will be limited to 20 men and will not be given for less than 10. Registration closes August 1st. Registration fee is $10. Accommodations for room and board can be arranged at the nearby Professional Schools Y. M. C. A.

Apply for registration of course to Dr. F. H. Falls, Research and Educational Hospital, 1853 W. Polk St., Chicago 12, Illinois.

NAVY'S NEW MEDICAL TRAINING PROGRAM

The Surgeon General of the Navy has announced the expansion of the Bureau's professional training program for reserve and regular medical officers, which is similar to the recently expanded Army medical training program. The object is to permit more Navy doctors to meet the requirements for certification by the various American Specialty boards, and to encourage the young doctors to intern under the auspices of the Navy. The following are the important points in this program:

Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the A.M.A. may be commissioned as lieutenants (junior grade), MC, USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event if an emergency.

The Navy has at the present time 400 approved residencies and fellowships in the various specialties recognized by the American Specialty Boards in Naval and civilian hospitals. This educational training involving the 400 residencies is divided into 2 programs.

Program A: One hundred of the above-mentioned residencies, courses, and fellowships will be available for civilian physicians accepting a commission in the U. S. Navy. An additional 100 civilian physicians will be commissioned in the U. S. Navy and permitted to pursue their own course, fellowship or residency, provided it is approved by the Council on Medical Education and Hospitals of the American Medical Association with concurrence of the Specialty Board. Upon acceptance of the designated training, they will be required to agree to remain in the Navy for a certain obligated time.

If on original appointment a candidate has not been approved for more than one year of training, during his first year of residency training (Program A) he may compete for one of the 300 residencies (Program B) available to the Regular Naval medical officers, and if he obtains such training he will obligate himself to remain on active duty for an additional period depending upon the amount of time spent in training.

Program B: Three hundred residencies, fellowships or courses, will be reserved for continuing the Training Program as presently organized for regular medical officers.

The obligated service following graduate medical training courses, fellowships and residencies) in Naval hospitals is one year for each year of training received.

Information concerning any part of the program may be obtained by writing the Chief of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

REORGANIZATION OF THE ILLINOIS NATIONAL GUARD MEDICAL DEPARTMENT

To the Editor:

The Surgeon General's office of the State National Guard headquarters has been reorganized and the appointment of Lieutenant Colonel Arthur E. Diggs of Chicago, Illinois, as Assistant Surgeon General is announced by the Surgeon General, Brigadier General Benedict Aron, also of Chicago.

This office is a section of the Adjutant General's Office in Springfield, Illinois, and its main mission is the processing of claims made against the State by guardsmen incurring sickness or injury while on State duty. With the increased personnel of the Illinois National Guard this office is charged with the duty coordinating the medical service of the various guard units.

General Aron is well known in medical as well as National Guard State circles, having held the position of Surgeon General of Illinois since 1945. He was appointed Assistant Surgeon in 1929. Prior to this appointment he served as Commanding Officer of the 122nd Hospital Company, 108th Medical Regiment. During World War I he served as Commanding Officer of the 129th Ambulance Company, 108th Sanitary Train, later to be known as the 108th Medical Regiment and at present the 108th Medical Battalion serving the 33rd Infantry Division.

Officers appointed in the Illinois National Guard Medical Department

Name	Rank	Location	Branch
Thaddeus F. Bush	Lt. Col.	Orchard Place, Illinois	MC**
Warren A. Colton Jr.	Major	Chicago, Illinois	MC**
Laverne V. Levredge	Captain	Chicago, Illinois	MC**
Frank Lock	Major	Chicago, Illinois	MC
Elvin M. Hartlett	Colonel	Chicago, Illinois	MC
Robert F. Stokes	Major	Chicago, Illinois	MC**
Ivar E. Dolph	Lt. Col.	Chillicothe, Illinois	MC
John A. Newkirk	Captain	Chicago, Illinois	MC**
William H. Benner	Captain	Chicago, Illinois	MC**
Arthur E. Diggs	Lt. Col.	Chicago, Illinois	MC
Gustuv A. Schupmann	Major	Chicago, Illinois	MC
Robert T. Fox	Major	Chicago, Illinois	MC
Walter K. Robinson	Major	Chicago, Illinois	MC
Milton W. Buehrig	Captain	Chicago, Illinois	MC
Robert M. Younglove	Captain	Kewanee, Illinois	MC
Richard M. Karracker	Captain	Chicago, Illinois	MC
George A. Olander	Captain	Chicago, Illinois	MC
Standiford Helm	Major	Chicago, Illinois	MC
Carleton R. Smith	Major	Peoria, Illinois	MC
John R. Brazelton	Captain	Chicago, Illinois	MC
John F. Kerrigan	1st. Lt.	Chicago, Illinois	MC
Harold M. Perlmutter	Major	Chicago, Illinois	MC
John R. Tambohe	Lt. Col.	Chicago, Illinois	MC
James B. Fairbairn	Captain	Chicago, Illinois	MC
Theodore A. Texidore	Captain	Chicago, Illinois	MC
Theodore F. Zmigrodski	Captain	Chicago, Illinois	MC
Erwin J. Sarley	Captain	Chicago, Illinois	MC
Vincent C. Sarley	Captain	Chicago, Illinois	MC
Joseph I. Soffer	Captain	Chicago, Illinois	MC
William E. Cunningham Jr.	1st. Lt.	Chicago, Illinois	MC
Thomas J. Cole	Captain	Chicago, Illinois	MC
Louis H. Coggs	1st. Lt.	Chicago, Illinois	MC
Arnold H. Maloney Jr.	Captain	Chicago, Illinois	MC
Elbridge W. Telford	Lt. Col.	De Kalb, Illinois	MC
Stirling P. Stackhouse	Major	Ottawa, Illinois	MC
Louis Belinson	Captain	Ottawa, Illinois	MC
Paul S. Baur	Captain	Danville, Illinois	MC
Edward T. Baumgart	Major	Danville, Illinois	MC
John P. Pope	Captain	Waukegan, Illinois	MC

MC-Medical Corps.
**-Air Nat'l Guard

General Aron received wounds in action during World War I and was given several commendations and honors for his service. In civilian life he is a member of Saint Bernards' and Holy Cross Hospitals in Chicago, Illinois.

The New Assistant to the Surgeon General, Lieutenant Colonel Arthur E. Diggs, also of Chicago, is another old time guardsman, starting his military career as a member of the Marine Corps in 1918 and 1919 serving in World War I. In 1923 he was given a reserve commission in the Engineer Corps and held this appointment until he became Regimental Surgeon with the 203rd Coast Artillery in 1931. During World War II he served as Chief of Surgery for the 163 General Hospital in England. On return to this country he became the Division Surgeon for the 33rd Infantry Division, and continued in this position until assigned to the State Detachment as Assistant Surgeon General. In civilian life he is a practicing physician on the Presbyterian Hospital Staff, the children's Memorial Hosp. staff and is Assistant Professor of Surgery, University of Illinois Medical College.

Replacing Colonel Diggs as 33rd Division Surgeon is Lieutenant Colonel Durand Smith, assistant in Surgery at Northwestern Medical School. Colonel Smith began as a Reserve Officer 1939-1940. In 1940 he joined the Nat' Guard and served with Company G, 108th Medical Regiment. In 1941 & 1942 he was Operations Officer and Executive Officer, in 1943 he assumed command of the 108th Medical Battalion and retained this position until 1945 when he was assigned as Division Surgeon for the 33rd Infantry Division.

The Committee

SYPHILIS RECORDS OF ARMY PERSONNEL AVAILABLE

Dear Sirs:

It would be deeply appreciated if you would print the following notice in your publication:

The Veterans Administration has in its custody the majority of syphilis records of those Army personnel who were treated for this disease while in active service, and in many instances can procure informative data from the syphilis records of other than Army personnel. It is thought that many physicians treating veterans for syphilis as private patients would find a resume of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

Resumes of these records are available to physicians who are treating such veterans provided authorization for the release of the data is given by the veteran. Requests for the resumes accompanied by an authorization for the release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munition Building, Washington 25, D.C. It is most important that the veteran's Service Serial Number and other identifying information, such as the date of enlistment, the date of discharge, rank, and organization be included.

Ordinarily, the resumes can be furnished in approximately two weeks from the date of the receipt of the request and signed authorization.

Sincerely Yours,
Paul B. Magnuson
Chief Medical Director
Veterans Administration,
Washington, D. C.

BUREAU OF MEDICINE AND SURGERY NEWS

Rear Admiral Clifford A. Swanson, MC, USN, Surgeon General and Chief of the Bureau of Medicine and Surgery, announces that a new residency in General Practice will be inaugurated in Naval Hospitals on July 1, 1948. The Professional Division of the Bureau of Medicine and Surgery has developed a residency in that phase of medicine which is required to augment the several medical specialties recognized by the American Specialty Boards in order to supplliment the residency training program, now operative, which is designed toward specialization. The program, as planned, will cover a peroid of three years. During each year of this residency Medical Officers will receive six months of training in General Medicine and related specialties, and six months in General Surgery and related specialties. Instruction will be provided by the staffs of the hospitals and outstanding civilian visiting staffs. With the introduction of this type of training Navy medicine has recognized the great need of the General Practitioner in the field of medicine.

MEDICAL ECONOMICS

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Carroll C. L. Birch, Hubert L. Allen.



Economic Significance of Pre-Employment Examinations

The number of employers who require physical examination of applicants for work is steadily increasing. Problems have arisen in that connection which are of economic importance and which are of interest to the medical profession. It might appear that the basic idea in the average examination program is to procure healthy employees and consequently an increase in production but when the steps in the development of the average industrial health plan of today are studied a different viewpoint may be obtained.

The results of examinations designed to eliminate applicants for employment who have physical defects have seldom been entirely satisfactory. In industry the use of time and labor-saving machinery had the effect of removing emphasis from strength and endurance to factors such as talent and adaptability. There remained only limited fields where the capacity of the strong was always greater than the weak and that employers were still desirous of having an accurate knowledge of the physical condition of their employees was explained by their need for protection against unwarranted claims for disability.

The problem of hernia was one of the first to become of medico-legal importance. The avoidance of claims for this one ailment often made physical examinations valuable and there have been times when all that certain employers required was to make an examination for that condition. The scope of the examinations nevertheless increased as newer types of claims were devised. The condition of a workman's back rapidly became a focus of attention and a limited number of employers found it advantageous to obtain x-ray films of prospective employees' spines. The presence of narrowed vertebral bodies, obliterated intervertebral spaces, divided transverse processes, arthritic spurs and every other type of spinal lesion have been the subject of legal dispute and the advantage of recording their presence at the time of employment became clearly apparent.

The occupational disease laws played a further important role in attracting the attention of the employer to the physical condition of his employees. It was largely because of these laws that x-ray examination of the chest first gained favor. Numerous applications have been filed seeking recovery for damage resulting from pneumoconiosis when other chest lesions of long standing were all that could be found. It is in

these conditions that films made of the chest at time of employment and at intervals thereafter have proven invaluable. Among laboratory procedures, in addition to the x-ray examination and simple urinalysis, the serological test gained greatest popularity. Efforts of public health authorities were largely responsible for the numerous blood tests made and contrary to the intentions of either the health departments or the medical profession the findings became a factor in determining the employee's position as a so-called occupational risk.

It must be admitted that the advantages to the employee of the various types of examination came as side effects and it must be conceded that extensive facilities which are now devoted to industrial health are not entirely a realization of original plans.

Economic questions which arise as the result of appraisal by the employer of his employee's health are possibly more numerous than important. The various problems of ethics which arise in this connection can be similarly classified. The most frequently presented question is with reference to the man who is rejected for employment because of one or more physical defects. This situation can easily be pictured as a hardship and can be readily dramatized. The fact is that the majority of such defectives can find work even though they may not be hired by the firm with whom they are most desirous of obtaining employment. The trend of present day thought offers a different solution to this problem and where applicable it represents great advancement in human relations. The term pre-placement examination is frequently substituted for pre-employment examination with the intention that within reasonable limits every man should work and that the examination should merely appraise his physical capacity and to some extent his aptitudes.

The extent to which the pre-placement type of examination has been accepted is not great. The notable exception is in the case of the disabled war veteran. Other defectives are hired by numerous firms as a matter of policy and at times very profitably but the number of companies who can afford this risk is *very* few. A very lenient attitude on the part of industrial boards is blamed by some for the strict rulings of many employers and it is very possible that this factor is responsible for keeping many individuals from desirable places in industry. The inelasticity of wage rates in many industries which are under the control of unions also acts as a deterrent to the hiring of the type of handicapped individual whose production would be below average.

Within the medical profession difference of opinion of the workman's doctor and the company examiner is possibly the greatest source of controversy. Rejected applicants frequently reappear to employment managers with a note from their family physician declaring that they are free from physical defects or that those which are demonstrable are not disabling. There is conceivably a tendency in this connection to permit the desires of the patient to be reflected in the doctor's decision even though the content of his statement be entirely true. Conversely the physician engaged by the employer may be too strict in his interpretations of potential claims for disability, absenteeism and possible hazards. The pre-placement type of examination offers a solution to such controversies. However, the reasons already mentioned explain why the procedure is not more widely accepted. This discussion is not intended to imply that a stalemate exists in the placing of those who are incapacitated in suitable gainful occupations. Much has been accomplished and steady progress will undoubtedly be made. This advancement will be by way of free enterprise as it has been until now. Impetus will be derived from government, public opinion and the trade unions but until the employer is no longer indirectly penalized it is not likely that complete cooperation will be obtained. —T.C.B.

COMING! Our August issue will carry a complete picture story on the 1948 Annual Meeting.

HOUSE OF DELEGATES



FIRST SESSION, MAY 10, 1948

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Palmer House, Chicago, on Monday, May 10, 1948.

The meeting was called to order at 3:15 P.M. by the President, Dr. Irving H. Neece, Decatur.

The first order of business was the roll call of officers and members of the Council.

The next order of business was the report of the Credentials Committee.

DR. E. S. HAMILTON, Kankakee: The Credentials Committee reported there are present and certified 61 delegates from the Chicago Medical Society, 70 from downstate, and 19 officers and members of the Council, making a total of 150. I moved you, Mr President, that this constitute the voting strength of this House of Delegates. (Motion seconded by Dr. Anders Weigen, Chicago, and carried).

THE PRESIDENT: The next order of business is the approval of the minutes of the annual meeting, May 12 - 14, 1947.

DR. W. E. KITTLER, Rochelle: If there are no objections or corrections, I move that the minutes be accepted as published in the July and August, 1947 issues of the Illinois Medical Journal. (Motion seconded by Dr. John W. Long, Robinson, and carried).

THE PRESIDENT: The next order of business is the appointment of Reference Committees. The following Committees have been appointed:

Committee on Credentials: Drs. Edwin S. Hamilton, Warren W. Furey, Walter E. Kittler, Willard O. Thompson.

Committee on Attendance: Drs. R. C. Oldfield, Richard Greening, James Taylor, H. E. Ryan.

Committee on Reports of Officers: Drs. Charles H. Phifer, Chairman, Fred H. Muller, W. J. Gillesby, Albert Nehf.

Committee on Reports of Councilors: Drs. L. O. Frech, Chairman, W. H. Newcomb, G. H. Mundt, A. M. Vaughn.

Committee on Reports of Standing Committees: Drs. J. P. Simonds, Chairman, Karl Vehe, G. E. Kirby C. E. Clark.

Committee "A" on Reports of Council Committees: Drs. F. M. Hagans, Chairman, L. S. Reavley, M. M. Hoeltgen, J. J. Moore.

Committee "B" on Reports of Council Committees: Richard Greening, Chairman, J. H. Hutton, H. A. Felts, Frank Deneen.

Committee "C" on Reports of Council Committees: Drs. C. Paul White, Chairman, H. A. Felts, W. O. Thompson, Robert Mustell.

Committee "D" on Reports of Council Committees: Drs. P. R. Blodgett, Chairman, J. E. Fleischner, Mather Pfeiffenberger, J. S. Templeton.

Committee to Receive and Report on Reports of Editor, Committee on Scientific Work, President of the Woman's Auxiliary, Advisory Committee to Woman's Auxiliary: Drs. D. B. Freeman, Chairman, D. H. Trumpe, B. E. Fillis, L. S. Tichy.

Committee in Miscellaneous Business: Drs. A. L. Linowiecki, Chairman, J. C. Redington, J. H. Edgcomb.

Committee on Resolutions: Drs. R. K. Packard, Chairman, H. W. Miller, E. H. Weld, W. W. Fullerton.

THE PRESIDENT: The next order of business is the presentation of Annual Reports. These have been published in the Handbook but they can be supplemented if so desired.

1948 REPORTS OF OFFICERS

REPORT OF THE PRESIDENT

To the Members of the House of Delegates:

Since last we met, another year has passed into history. As the 108th President of the Society, it is my

privilege to render an account of proceedings during my term of office. Looking back rather humbly at our accomplishments, it may be timely to remind you that your officers serve you and that, although they may seem to influence your course of action at times, the final outcome rests upon your decision in all matters of growth and development.

As you already know, the work of the Society is carried on by the Councilors between the Annual Meetings and may I say, at the very beginning, that I have never seen a more hardworking, more self-sacrificing and more interested group of men than those who compose the Council of the Illinois State Medical Society. The hours spent on deliberation over the multiplying problems which weekly and monthly come before the members and the various committees of this Society are an appalling total and I want to thank each and every member of the Council personally for the fine spirit of cooperation that has been manifest in all its meetings thoughout the year.

All over the State there is every evidence of a restoration normal medical service to the communities which was lacking during the war years. Most of the returned medical veterans have finished their residencies and are locating, for the most part, in the larger centers. The Illinois State Medical Society has reached a new high in membership, but its problems are becoming more and more complex. It is encouraging to note that many of the younger men are accepting leadership and responsibility, especially at the county levels. However, at this very moment there is sober discontent in the minds of many of the younger men as the world awakens to the Red peril which seems to be spreading rapidly throughout all Europe and the East. This country has begun to think in terms of rearmament before the deep scars of the last war are healed. A wave of discouragement and uncertainty seems to be gripping the hearts of the younger members, especially those who are just entering or reestablishing their practices. The Administration, Congress and a large section of the public are gradually becoming awake, in the last few weeks, to the dangers which threaten us more than ever in history. Fine speeches, official statements about the "ominous situation" and off-the-record hints that we may soon find ourselves in a difficult situation are being made every day, but nothing very practical is being done to counteract this grave situation whenever it does occur.

As we contrast conditions that prevail in socialistic and communistic countries with those in our own, we fully realize that the net worth of an *unregimented medical profession* is beyond human appreciation. We learned that from the distressed people of other countries, who did not realize the value of a free medical profession until that great asset was lost as the result of nationalization of industries and the professions. The physicians of the United States have well answered the question, "Is organized medicine able to deliver adequate medical service to all the American people?" The task of the officers and the committees of each County Medical Society is to take inventory of the most important items of the great backlog of material available, then set to work in their own way on medical service programs that best suit their individual communities.

There are thousands of American medical men who by virture of military service in World Wars I and II have seen what foreign medical systems are and do. These men know what American medicine is and does. They, truly, are the experts whose first-hand experience can give the most pertinent, comparative evaluation of the various systems concerned.

The American system of medical practice is not yet perfect. It is doubtful if any individuals recognize that fact more thoroughly than American medical men themselves. They, too, want change, but they insist that any change must carry with it a guarantee of improvement of service to the people.

To every thinking individual it must stand to the everlasting credit of the American medical man that he is placing the welfare of the people first and is an "unwilling profession;" unwilling, that is, to subscribe to any plan that can not guarantee better medical care than is now available. Numerous local and state insurance are now operative or in the process of formation. Change alone is easy to achieve, but that is not enough.

Any change to be acceptable must be a change plus better medical care.

The Council

Under the splendid leadership of its chairman, Dr. Walter Stevenson of Quincy, the Council has met on the average of once a month during the past year. Dr. Stevenson has served with fidelity and ability in this important assignment for two years and has had the loyal support of the Councilors in all his decisions. He has directed the affairs or the Council in a very efficient, commendable manner. His unbiased judgment, his sense of fairness and cooperation, his keen insight into the many medical problems confronting the Council, and his fine amiable spirit have won for him an enviable place among the members of the Council. His work merits the commendation and thanks of this House of Delegates.

The Secretary

An ever increasing amount of work is placed on the Secretary of this Society, Dr. Harold M. Camp of Monmouth. With his well-trained staff, the office of the Secretary has carried on with the usual high degree of efficiency. His long years of service as secretary have qualified him in a most excellent way to guide and direct the many problems of the Society. This back-ground of experience is a great asset to the Society. Dr. Camp has served for nearly twenty-five years in a position of importance in a Society that has grown from a relatively small one to the third largest in the United States in point of membership, with ever-increasing demands on his energy, ability and time. I would like to suggest that the House of Delegates carefully consider the advisability of employing an assistant Secretary to help him carry this ever-increasing load.

The Editor and the Editorial Board

The Editor and the Editorial Board are to be commended for their splendid work during the last year in putting out a Journal of which any State Society would be proud. Under the handicap of a paper shortage which extended well into late 1947 and 1948, some embarrassing delays in getting out the Journal on time were encountered. The Editor and the Editorial Board are to be commended for their fine spirit and for the attractive Journal which they have produced. The work of the managing editor, Mr. Ed Malley, merits special mention and commendation for the selection of the ethical pharmaceutical and other advertising in the Journal. The *Illinois Medical Journal* is now self-supporting.

The Department of Public Health

I am happy to state that the Department of Public Health of Illinois is working in close harmony with the officers and Council of the Illinois State Medical Society. Since the program is regularly presented to the Council of the Illinois State Medical Society by its Director, Dr. Roland R. Cross, the Council has been kept fully informed of all the developments within the department.

As reported to the last House of Delegates, the Illinois Hospital Survey had been completed and plans for construction of hospitals under the Hill-Burton Hospital Construction Bill have been worked out in the year since. Through the Advisory Hospital Council, six hospitals with "A" priority rating have been approved. Five million dollars has been allocated to build tuberculosis hospitals in Savanna, Mt. Vernon, and Chicago. The Cancer Diagnostic Centers have increased from four to sixteen and some four thousand patients have been seen. The Rapid Treatment Centers for indigent syphilitics have been established in twenty-four hospitals and 1,604 patients have been treated by this method. 28 county health units have been established throughout the State and a number of other counties are in process of formation. These are but a few of the highlights in the Department of Public Health activities which the Council has approved. Many of the Council members are now serving on committees having to do with these projects. Dr. Cross is to be commended for his fine spirit of cooperation.

Public Relations

The year 1947 saw significant extension, under the Committee on Medical Service and Public Relations, of the Society's public relations program and a marked advance on the part of individual doctors, and of County Societies, in understanding and using the facilities of the office of our Public Relations Counsel, Mr. James C. Leary.

The work of our public relations organization may be divided into two principal functions: First, consulting in the formulation of or familiarity with Society policies, almost all of which, it grows daily more apparent, have a direct bearing on the nature of the relationship between the medical profession and the general public; second, communicating the news of the Society and the priniciples and attitudes of organized medicine in effective and attractive form to the people of Illinois and to the country as a whole.

At the level of planning and policy formulation, Mr. Leary attended all Council meetings of the year and maintained constant and close liaison with the Society's officers. Almost no Society problem or policy of any consequence was considered during the year without the participation of our Public Relations Counsel and Mr. John W. Neal, Executive Secretary of the Committee.

At the level of communication, the year saw important progress in telling effectively the story of organized medicine to the whole State. This is not the place to recount in detail the hundreds of news stories, photographs, special articles, radio broadcasts and other avenues of communication involved. Special mention may be made, however, of the extensive summary of the Society's successful contribution for improving conditions of rural medical care during the year, which was distributed to every newspaper in the state, and commanded space in newspapers throughout the country. Also worth mentioning is the supplying to weekly newspapers a column which tells valuably and directly the story of modern medicines in terms of the layman's own health, a function of the Educational Committee. It is becoming increasingly evident that awareness of the importance of medical public relations is growing within organized medicine throughout the nation. The public relations committee and its Counsel, Mr. Leary, are to be congratulated for their fine work during the year.

I wish to pay a special tribute at this time to the loyalty and devotion of the Executive Secretary, Mr. Neal, for successfully combating and defeating the Cult Bills at the last General Assembly. Without his thorough knowledge of the issues involved and his untiring zeal and effort, this achievement would not have been possible. This gigantic piece of work merits a vote of thanks from all the members of the House of Delegates. The Council of the State Society continues to lean heavily upon him for his opinions and legal advice.

Time does not permit me to discuss the work of all the organized committees of the Council except to say that every committee has been functioning efficiently throughout the year and that their reports will become a part of this official annual report to the House of Delegates.

Recommendations of the President of the Society

With almost a quarter of a century of thoughtful service on the Council behind me, I have developed some rather positive opinions on many of the matters which concern all of us as members of the medical profession. I have several recommendations which I wish to bring to the House of Delegates for consideration. I believe that none of them is original with me and most of them have been discussed and considered by many of you. The Council has considered some of these matters and has taken action on many of them.

I wish to speak of medical education. It is an understatement to say that, from a scientific standpoint, medical education in this country is excellent and is improving constantly. We are justifiably proud of our 67 Class-A medical schools in the United States. Nevertheless, I feel certain needs of the medical students are not entirely met.

(a) I would like to recommend that students be given definite information and instructions on the economic problems of medical care, its costs, problems of its distribution on prepayment, hospital and medical plans and on the philosophy and the basic factors which have brought American medicine to its present high level of achievement.

(b) I also wish to recommend that medical students be made more aware of their responsibilities to the medical profession and also of their responsibilities to the community as future prominent and respected citizens. Many a young physician becomes so engrossed in a very busy practice that the community loses the benefit of his advice on and his participation in civic matters. Of course, many medical men do put in long hours at great personal sacrifice trying to help solve community problems. Every local medical organization needs the active cooperation of every medical man in the community. I believe that a definite lecture course to show students their responsibilities to medical and civic organizations would be of great value.

(c) I also recommend that every medical graduate have at least one year rotating internship in an approved hospital before advancing to specialized fields. It is my opinion that every medical man needs this background of diversified experience and training before concentrating his efforts in a special field. I know of many medical students who desired rotating internship but had to be content with specialized internship because so few rotating internships were available.

Next, I wish to speak of the education of the public in matters of health. It is both our duty and our province to give the people of this state all the information on health subjects that we can. The medical profession is the authoritative source of such information. We should be the spokesman for its dissemmination. This education of the public in matters of health is the only effective foundation on which to build improved public relations.

(a) I recommend that we constantly try to improve the hygiene and other health courses in grade schools, high schools and colleges.

(b) I recommend that we make greater efforts to inform the public of the value of medical care, what medical care can achieve, when they should seek it and how they may obtain it.

(c) I recommend that we develop a definite organization to show to communities which lack accredited hospital facilities, the value of such hospitals and follow that up with our support in obtaining these hospitals.

(d) I recommend that medical men speak to more lay meetings. There should be more public forums at which medical men may lead the discussions on scientific accomplishments and the economic problems of medicine.

Third, nursing education is in a critical position. There is an extreme shortage of graduate and undergraduate nurses. This is bound to reflect on the quality of hospital care. Nursing and hospital organizations are, at present, in a vigorous campaign to recruit a greatly increased number of qualified student nurses. We should help this recruiting program in every way possible. Many hospitals hesitate to plan critically needed additions because of fear that they can not staff them adequately. I recommend that we cooperate actively with both nursing and hospital organizations to help solve this shortage. It is possible that this shortage may be partly due to too high educational standards of training schools for nurses. We should also not forget that nurses are educated, professional people, not menials, but many are working at jobs where they are backed by labor unions rather than professional organizations. It has been suggested by the American Nurses Association that there are plenty registered nurses. To get them, accept them as professional people and pay them as such. The ANA holds that the crisis in nursing will be overcome only when the profession is made sufficiently desirable to attract and retain a sufficent number of qualified women.

Fourth, the activities of the Department of Public Health in Illinois have expanded greatly in the last generation and will probably continue to do so in the coming years. I am happy to state again that your officers are working in close harmony with the Director of the Department of Public Health. However, many of us as individuals are not thoroughly acquainted with the various phases of the program of the divisions of health. Without complete understanding of its program, we can not cooperate fully with the personnel of the department. I recommend that we try to keep our members more fully informed on the problems and activities of the Department of Public Health.

Fifth, solving the rural health problem, the serious shortage of both medical men and hospital facilities. has been one of our major problems for many years and will continue with us in the future. We have hospital legisation which will help develop or enlarge hospital facilities in areas in which they are needed. We must support this program vigorously and give the people of the communities concerned information on the benefits of accredited hospitals so that they will vote the necessary bond issues for their construction and the necessary taxes for their maintenance. We know that hospital facilities bring young medical men to these areas. I recommend that we support this hospital construction program to the limit of our ability.

I would like at this time, to extend my personal appreciation to the officers of the Society, to the members of the Council and to the members of the various committees, both standing and special, for their untiring

efforts to complete the various duties that were imposed upon them.

Respectfully submitted,
I. H. Neece, M. D.,
President, Illinois State Medical Society.

REPORT OF THE PRESIDENT-ELECT

To the Members of The House of Delegates:

The report of the President-Elect to the House of Delegates is limited to the statement that he has continued in his attempt to familiarize himself with the activities of the Illinois Medical Society by attending many meetings in the Councilor Districts of the State; by attending all the meetings of the Council and many committee meetings during the past year. It has also been his pleasure to address lay groups on economic subjects and medical organizations on professional topics during this time.

It has been his pleasure and privilege to be able to attend practically all of the postgraduate meetings and present to those attending the Illinois Plan for Prepayment Medical and Surgical Care.

Respectfully submitted,
Percy E. Hopkins, M. D.,
President-Elect, Illinois State Medical Society.

REPORT OF THE SECRETARY-TREASURER

To the Members of The House of Delegates:

It is once more a pleasure to present the annual report to this House of Delegates and endeavor to show what has been accomplished in the Secretary's office during the past fiscal year, and to elaborate on some of the more important projects which have been presented to us in this period.

For a number of years the records of the Secretary's office and those of the membership department in the American Medical Association were considerably at variance, there being a difference at times of perhaps 200 members. We have naturally been interested in our membership, and have tried in every way possible to make the best possible showing in the A. M. A. reports. Last fall we sent Miss Jane Zimmer from the Monmouth office to the A. M. A., where she took our complete membership date, and checked it against their files, this requiring a week or more for the complete check-up.

Since that time we have been corresponding with the head of the A. M. A. membership department, Mr. A. W. Stack, and we have gradually reduced the variance until our records are closer together then ever before. It is extremely difficult in a large society to keep the membership records straight, although we have repeatedly asked all component society secretaries to notify our office promply when a member dies, or removes from their jurisdiction. We still occasionally have a death reported anywhere from one to three years after it occurs, which makes it embarrassing to all of us. Occasionally the post office gives the first information concerning the death of a member to whom some announcement has been sent. We hope in the future that this condition will not exist, and that we will be promply notified of any changes in membership records of component societies.

Although there has been a considerable number of additions to the membership during the past fiscal year, the actual count of members is not much greater than was reported a year ago. However, we have removed quite a number of names from the list as reported last year as a result of a careful check on membership with each individual county medical society. We had been carrying names of physicians who should have been dropped, but were still retained on membership lists of many of the county medical societies.

The Chicago Office

For many years, the Chicago office was designated as the office of the Educational Committee, and the work done in this office was principally that pertaining to the Educational Committee, Scientific Service Committee, and the Postgraduate Education Committee. Formerly the Scientific Service Committee was designated as a sub-committee of the Educational Committee, but this was changed several years ago, making the latter an independent committee.

The Council when approving the enlarging of the suite at 30 North Michigan Avenue, Chicago, wisely provided that it should be designated the Chicago office of the Illinois State Medical Society. The Educational Committee, Scientific Service Comittee and Committee on Postgraduate Education still operate through that office, but it is likewise the business office for the Illinois Medical Journal, the Council on Medical Service and Public Relation, and for several committees. A considerable number of conferences of Society officers, Committees, as well as other groups are held in this office during the year.

When it was deemed advisable to increase the office personnel last year, Miss Josephine Linder, a highly competent stenographer was employed. This expense was not charged against the Educational Committee, but she was designated by the Council as an employee of the Society, and her services were made available to committee desiring clerical assistance. This provision has worked out well, and even though more of her time is devoted to work for the three primary committees formerly headquartered there, she has been of much assistance to a number of committees, Councilors and Society officers requiring stenographic help.

Location of Physicians in Rural Areas

One of the functions of the Procurement and Assignment Service was the re-location of physicians, especially in rural areas, and a considerable amount of time and effort was required to carry on these duties. When Procurement and Assignment Service was ended, the state medical societies assumed the responsibility for aiding returned medical veterans and recent graduates in finding a suitable location.

We have received many requests for information from physicians not only from Illinois,but likewise from a number of other states. Before giving these inquirers any information as to locations, we send them a questionnaire form to get information concerning their own background, when we render all possible aid

by sending them lists of communities desiring a physician, with information concerning the community, roads, schools, population, the surrounding territory covered by a physician in the area, etc.

This information is prepared in mimeographed form, and does contain much factual data to aid the physician in determining the localities he desires to investigate. Formerly we sent good physicians into some rural towns, then found that the community was not interested in aiding the physician to find a suitable home, or office space. In one instance, a fine young physician desiring a location and who was willing to go into the town under investigation, was told that there were no homes available in the town, but a tenant house could be used on a farm three miles from the town. Naturally he did not locate in this town.

When letters are received asking for aid in procuring a physician, we invariably insist that office space and a suitable home for the physician be available before we send out the information to physicians interested. We have had a number of small towns desirous of getting a second physician, when similar size towns in the vicinity had no physician at all, and we have invariably tried first to get the latter supplied before endeavoring to get a second physician for any small town.

Our own surveys, along with those of the Committee on Rural Medical Services, do not show an unusual need for physicians in rural areas of Illinois. This does not mean that there are no small towns without physicians, but we mean there are few areas which cannot be reached within a short time by physicians located in the immediate vicinity. We frequently have committees from Women's Clubs, P. T. A., or several other similar types of groups, coming to the office in the effort to get a physician in their community. We invariably listen to their story, and make notes, which are used later to get factual data for our mimeographed lists. We insist that a home and office be made available before we recommend that their community be investigated by physicians desiring a location, then do everything possible to aid them.

A short time ago we had a letter from an irate resident of a small community, in which he asked that we immediately find another physician for them. He stated that although they have one physician, he insists on taking one afternoon off each week and cannot always be found on Sundays, and he insists on a week's vacation during the summer. They want a physician who will be on duty all day, seven days a week, and no afternoons off, and no vacations, so that if people want him, he will be there.

The Society

Reference will be made in other reports in this handbook to the change in the former Veterans' Service Committee, which now has a new designation and additional duties. The American Medical Association had created a new Council on National Emergency Medical Service, and requested cooperation at the state and county levels. The Council, which was responsible for the development years ago of the former Veterans Service Committee, decided that this committee could likewise be used to cooperate with the A. M. A. Council. At the meeting on March 7, the Council heard a report from the Veterans' Service Committee, which had met a few days previous to the meeting, in which they recommended a change in the name of the committee.

The Council, therefore, approved the recommendation that the committee personnel remain the same, and the name be changed to "Committee on Military Affairs and Emergency Medical Service." We heard many references during the late war to statements that the Army and Navy were procuring more medical officers than were actually needed. The Surgeons General offices requested a committee from the A. M. A. to plan with them for possible future war, or other national emergencies, as to medical personnel.

In the event of another war, or any other national emergency, our new committee should be of much service in aiding the A. M. A. Council, as well as Government officials or agencies in procuring information at the state level pertaining to the availability of medical personnel from this state.

It has been necessary for the Council to name some additional committees for specific purposes during the year, and each of these committees has been unusually active. The Advisory Committee to the Illinois Public Aid Commission has met regularly with officials of the commission in the effort to carry on this important work. Doctor Coleman, as chairman of the Committee, has an interesting report in this handbook, which we hope every member will read when it is published in the transactions in the July and August issues of the Illinois Medical Journal.

The Committee on Voluntary Prepayment Plans for Medical and Surgical Care has met frequently during the past year and has endeavored in every way possible to get more insurance companies interested in the Illinois Plan. The handbook, copies of which are available for all members of this House of Delegates, has been completely revised, and is being sent out to many insurance companies, to all county society secretaries, and to others who have asked for it. We hope that you will all read the report of the chairman of this committee, and see the many problems which have been encountered during the past year.

Much publicity has been received following the announcement of the joint program of the Illinois State Medical Society and the Illinois Agricultural Association in the effort to get young men and women from rural areas interested in studying medicine, and returning to their own home counties to practice. Doctor English, as chairman of the Committee on Rural Medical Service, has an interesting report published in this handbook for your careful consideration.

Postgraduate Education Conferences

The Council, following the recommendations a year ago of the House of Delegates, authorized the scheduling of 12 postgraduate conferences during the fiscal year. Twelve were arranged, but one of these was cancelled, and will be held during the fall. Eleven have

been held, and the reports from all of them have been most complimentary. The plan of beginning at noon with a luncheon with the compliments of the host society, then a full afternoon program, round table discussions in the late afternoon, then a dinner and evening meeting, seems most satisfactory to the membership as a whole.

The conference held at Decatur on March 25 was attended by more than 200 for the afternoon session, then for the evening meeting the total attendance was approximately 300. Marjorie Shearon, Ph.D., of Washington was the after-dinner speaker and her talk was of great interest to all those present. There were about 50 members of the dental profession present, and many business and professional men and women from in and around Decatur.

Two or more representatives from the Secretary's office attend these postgraduate conferences, and conduct the registration, selling of dinner tickets, and other services in the effort to have a successful conference. The printing is done through the Secretary's office, and announcements and return post cards are all sent from this office, using the Society addressograph equipment for the mailing lists.

Deaths of Prominent Members

Once more it becomes our duty to report the deaths of a number of prominent members of this society, including one past president who had worked faithfully over a long period of time for the best interests of this society and the medical profession of Illinois.

Samuel Edgar Munson, Springfield, was born August 25, 1866, and was graduated from Northwestern University Medical School, Chicago, in 1893. For a few years he practiced at Mt. Pulaski, then moved to Springfield where he maintained a practice continuously until his death on October 2, 1947.

For a considerable period of time he was councilor for the Fifth Councilor district, then in 1937 he was elected as President-Elect of this society, serving the following year as president. As an outstanding internist at Springfield, he wrote many scientific articles for publication in various medical journals. He was a member of quite a number of organizations, including the American College of Physicians, of which he was a charter member, and for some period of time a member of its Board of Governors. A member of the Fifty Year Club, Doctor Munson was interested in the honoring of men who similarly had completed 50 years of practice, and aided materially in welcoming a number of these men into the club.

Harry Otten, Springfield, died February 18, 1948. He graduated at Rush Medical College in 1913, and following an internship and residency located at Springfield, where he practiced continuously until his untimely death from a coronary occlusion. Doctor Otten, a past vice-president of this society, was a Fellow of the American College of Surgeons, and he was principally interested in the early diagnosis and care of malignancies.

He was in charge of the tumor clinic at Springfield for several years, and was quite active as a member of the Committee on Control of Cancer. A regular attendant at the annual meetings of this society, he was known by many of the members, many of whom have served with Doctor Otten in one or more of his various capacities.

M. Herbert Barker, Chicago, died August 14, 1947, while making his rounds at Passavant Hospital. Doctor Barker was associate profesor of medicine at Northwestern and in charge of the cardiovascular-renal clinic and laboratory. He entered the medical corps, U. S. A., in 1942 as a Lieutenant Colonel, later being promoted to Colonel, and was awarded the Legion of Merit for his outstanding work in infectious hepatitis. Doctor Barker was a member of the Veteran's Service Committee and chairman of the Section on Medicine at the time of his death.

Harry W. Woodruff, Joliet, died June 20, 1947. An outstanding ophthalmologist, he was a member of many special organizations, and was on the staff of a number of special hospitals where eye work is done. He was formerly a vice-president of this society, a regular attendant at the annual meeting and on a number of occasions, was in the House of Delegates.

Charles Sumner Bacon, an outstanding obstetrician and for many years head of the department of Obstetrics and Gynecology at the University of Illinois College of Medicine, died June 10, 1947, at the age of 90. Doctor Bacon contributed freely to the current literature on Obstetrics over a long peroid of time, was a member of the Fifty Year Club and a regular attendant at the annual meetings.

George W. Michell, Peoria, died November 17, 1947. Doctor Michell was noted for his work in neuro-psychiatry, and maintained two fine institutions at Peoria for treatment of these cases. His Michell Sanitarium received patients from many states, and it is an outstanding institution of its kind in the Middle West. He was invariably interested in medical progress and medical societies, and was a frequent attendant at the annual meeting and at special meetings throughout the country.

W. L. Karcher, Freeport, died March 3, 1948. Doctor Karcher for a number of years was a member of the Medical Examining Committee, Illinois Department of Registration and Education. He was a member of many medical and surgical societies, and was a regular attendant at many of their meetings.

Willis O. Nance, a member of the Fifty Year Club, and an outstanding ophthalmologist, died in Los Angeles, January 16, 1948. He was well known throughout the country as a teacher and writer on ophthalmologic subjects.

Arthur E. Lord, Plano, died September 13, 1947. He served in World War I and in 1928 was appointed as Surgeon General of the Illinois National Guard, a position he held until one year prior to his death, retiring with the rank of Brigadier General.

Joseph B. Holmes, Macomb, for many years an outstanding surgeon for the downstate area of Illinois, died September 18, 1947. Doctor Holmes, a Fifty Year Club member, was always interested in the many

medical problems of the day, and was especially noted for his constant endeavor to help the younger men in practice.

Leslie P. Sloan, Oblong, was secretary of the Crawford County Medical Society for a number of years. He died of coronary occlusion on September 5, 1947. He was a frequent attendant at the annual meetings of this society and served faithfully in the office of secretary of his component society.

George W. Haan, Aurora, died February 9, 1948. For nearly 20 years he was health commissioner of Aurora, was a member of the House of Delegates, and participated freely in activities of the Section on Public Health and Hygiene.

George E. Shambaugh, Chicago, died November 30, 1947. Doctor Shambaugh was well known throughout the country for his work in otolaryngology, having been professor of this Department at Rush Medical School, then later professor emeritus at the University of Illinois' Rush Division. He too was a member of the Fifty Year Club.

George A. Green, Nashville, died November 27, 1947. For a number of years he was secretary of the Washington County Medical Society, which position he held until he became disabled. He was a frequent attendant at the annual meetings, and was a member of the House of Delegates.

S. B. Peacock, Pittsfield, died March 6, 1948 at his home, a few minutes after returning from a Florida vacation. A member of the Fifty Year Club and an active member of his county society for many years, Doctor Peacock was known over a large Central Illinois area. Although he invariably insisted that he was a country practitioner, he attended many medical meetings, and visited clinics at frequent intervals in the endeavor to keep pace with medical progress.

Time will not permit our telling about many other fine Illinois physicians who have been called to their eternal reward during the past year, but we will mention a number of them who have been active in the affairs of their local county and this state medical society. James Washington Dunn, Cairo, died January 10; Nelson A. Wright Sr., Manito, died March 25; Col. M. A. Reasoner, Alton, died June 20, 1947; John Henry Evans, Chicago, died July 15, 1947; William F. Schroeder, Rock Island, died June 10, 1947; George D. Hauberg, Moline, died June 23, 1947; Franklin A. Turner, Rockford, died August 7, 1947; Albert W. Meyer, Bloomington, died July 26, 1947; John Carroll Walters, Springfield, died December 29, 1947; Daniel E. Murphy, Chicago, died March 21, 1947; Charles H. McKenna, Chicago, died November 13, 1947; A. H. Waterman, Chicago, died November 26, 1947.

On looking over the reports of deaths of members we are once more reminded that many of them died at their posts, which we know is a tradition of medicine. They and their work, will long be remembered by the thousands who depended upon them in time of illness.

We again desire to express our appreciation to the secretaries and other officers of component societies for the fine spirit of cooperation which has been in evidence through another fiscal year. Without this assistance, the work in the Secretary's office could not be carried on to the best advantage of the Society. Likewise we want to thank the many committee chairmen, section officers, and others upon whom we have so frequently called for various types of information which has been promply given to us.

The Council has had a busy year with so many important problems brought before them, and we are once more appreciative of the support the Secretary's office has had from this fine group of men.

Membership Data

Members in good standing as of April 30, 1947		9,651
Added during the year:		
New members	733	
Reinstatements	46	
Total added		779
Total		10,430
Dropped during the year:		
Died	159	
Moved away	227	
Resigned	60	
Dropped for non-payment of dues	105	
Expelled	2	
Duplicates in files	10	
Adjustment due to A. M. A. checks	132	
Total dropped		695
Net Total, April 30, 1948		9,735

FINANCIAL REPORT OF THE SECRETARY-TREASURER

Receipts from County Societies

Adams	$ 620.00	Fayette	90.00
Alexander	260.00	Ford	175.00
Bond	80.00	Franklin	428.00
Boone	110.00	Fulton	250.00
Bureau	90.00	Gallatin	130.00
Carroll	230.00	Greene	140.00
Cass	182.00	Hancock	244.00
Champaign	840.00	Hardin	.00
Chicago Medical Society	59,999.00	Henderson	.00
Christian	290.00	Henry	540.00
Clark	120.00	Iroquois	360.00
Clay	100.00	Jackson	626.00
Clinton	10.00	Jasper	67.50
Coles-Cumberland	480.00	Jefferson-Hamilton	.00
Crawford	30.00	Jersey	50.00
DeKalb	350.00	Jo Daviess	78.00
DeWitt	180.00	Johnson	30.00
Douglas	190.00	Kane	2,200.00
DuPage	1,175.00	Kankakee	670.00
Edgar	170.00	Knox	450.00
Edwards	40.00	Lake	1,170.00
Effingham	430.00	LaSalle	916.00
		Lawrence	150.00

Lee	320.00	Pulaski	38.00
Livingston	370.00	Randolph	200.00
Logan	280.00	Richland	120.00
McDonough	470.00	Rock Island	1,010.00
McHenry	478.00	St. Clair	2,030.00
McLean	905.00	Saline	220.00
Macon	168.00	Sangamon	1,581.00
Macoupin	230.00	Schuyler	90.00
Madison	1,518.00	Shelby	210.00
Marion	402.00	Stephenson	740.00
Mason	100.00	Tazewell	560.00
Massac	80.00	Union	140.00
Menard	12.00	Vermilion	870.00
Mercer	30.00	Wabash	140.00
Monroe	110 00	Warren	240.00
Montgomery	420.00	Washington	88.00
Morgan	278.00	Wayne	90.00
Moultrie	20.00	White	160.00
Ogle	538.00	Whiteside	428.00
Peoria	2,060.00	Will-Grundy	1,120.00
Perry	250.00	Williamson	30.00
Piatt	10.00	Winnebago	1,770.00
Pike	180.00	Woodford	290 00
Pope	10.00		

Total $96,421.50

RECEIPTS AND PAYMENTS

Receipts

Component Societies	$ 96,421.50
Subscriptions—Journal	422.55
Advertising—Journal	57,593.89
Exhibits—State Meetings (1947)	3,047.50
Exhibits—State Meeting (1948)	6,865.00
Interest—Government Bonds	2,562.50
Dividends (C. & N. W. Ry Co.)	15.50
Liquidating Dividend—Sheridan Trust & Savings Bank	96.00
Miscellaneous and Refunds	220.08
Total Receipts	$167,244.52
Cash Balance, May 1, 1947	122,142.86
Total	$289,387.38

Payments

Secretary's Office Expense	$ 25,610.98
Council Expense	8,257.85
A. M. A. Meeting Expense	4,562.57
State Meeting Expense	16,745.88
Society Exhibit Expense	1,360.01
Legal and General Counsel Expense	500.00
Journal Expense	50,150.87
Fifty Year Club	192.98
Veterans' Program Expense	227.54
Conference of Presidents Expense	90.05
Secretary to Committees—Chicago Office	1,635.00
Committee Expenses:	
Advisory to Illinois Public Aid Commission	83.34
Archives	394.43
Educational and Scientific Service	15,963.30
Industrial Health	78.79
To Investigate Prepayment Plans, Medical and Surgical Care	3,823.47
Maternal Welfare	459.72
Medical Benevolence	11.66
Medico-Legal	128.60
Medical Service and Public Relations	26,824.38
Medical Testimony	18.99
Postgraduate	2,381.42
Rural Medical Service	10.00
Scientific Service	373.13
Tuberculosis	65.40
Social Security Taxes	309.05
State Unemployment Insurance	167.23
Federal Unemployment Insurance	69.85
Equipment for Chicago Office	890.87
Total Expenses	161,387.36
Investment — Government Bonds	25,000.00
Total Payments	$186,387.36
Cash Balance, April 30, 1948	$103,022.55
Less Social Security Taxes deducted from employees	22.53
	103,000.02
Total	$289,387.38

Respectfully submitted,
Harold M. Camp, M. D.,
Secretary-Treasurer.

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Bldg.
Rock Island, Illinois

April 26, 1948.

To The Members of The House of Delegates,
Illinois State Medical Society:

CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1948:

Secretary's Office—Dr. H. M. Camp,
Journal Office—Mr. L. E. Malley,
Educational Committee—Miss Ann Fox, Secy.,
Benevolence Fund—Dr. H. M. Camp.

This year in order to prepare the statements for the printer, so as to be included in the Handbook for the House of Delegates, it was necessary to exclude Cash Receipts and Payments after April 23, 1948. Subsequent receipts and payment will be included as transactions in the next fiscal year. This will not materially affect the Payments as all known expenses have been paid to date.

SECRETARY'S ACCOUNTS:

Receipts: Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society and compared with the Secretary's published report.

The Journal Receipts have been verified with reports from the Manager and reconciled with the Journal Advertising Accounts.

Bond Interest received was compared with Interest Due on Bonds. Other receipts consist of Exhibit rentals, Journal subscriptions, etc., which were taken into account as recorded. All receipts are recorded on the Secretary's records and deposited regularly in the depository bank.

Payments: Payments are made by check and are supported by approved vouchers, orders, etc.

All funds are deposited in the name of the Society and the cash balances as of the closing of the books (April 23, 1948) were reconciled with the depository bank statements and letters from the banks.

U. S. Government Bonds, amounting to $115,000.00 par value were examined. They are issued in the name of the Society. During the year bonds amounting to $25,000.00 were purchased. Other securities held are 31 and 70-100 shares of Common Stock of the Chicago and Northwestern Railway Company, which were issued in lieu of the bonds formerly held.

A liquidating dividend of the Sheridan Trust and Savings Bank was received amounting to $96.00. This was a Bank Waiver Claim on the Educational Committee and Journal funds, which were on deposit when the bank closed.

The accounts of the various departments have been well kept, and in my opinion represent the true transactions for the year.

The Council will be furnished with a detailed audit report which agrees in totals with the Secretary's report.

Respectfully submitted,
Fred N. Setterdahl,
Certified Public Accountant.

THE SECRETARY: There is just one thing I want to announce, that is the death of the Councilor of the Second District last week, Dr. H. L. Pettitt, Morrison. He died on May 6. This is not included in the printed report of the Secretary.

DR. W. E. KITTLER, Rochelle: I would like to make a motion that the House stand for one minute in memory of Dr. Pettitt. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

REPORT OF THE CHAIRMAN OF THE COUNCIL

To The Members of The House of Delegates:

Your Council has held 6 regular meetings since the last regular meeting of the House of Delegates and there has been one special meeting. Also there have been four meetings held during the convention in May. The regular meetings of the Council are held about every two months. They are held on Sunday morning at the Palmer House and are followed by a luncheon. Occasionally it is necessary to continue the meeting during the luncheon and afterward.

As has been customary heretofore, an Executive Committee meets on Saturday night before the regular Council session and tries to consider important matters which are on the agenda of the regular Council meeting in order that concise recommendations may be made to the Council, thus expediting the business of the Council.

The Executive Committee has no power except to make recommendations to the Council.

Again, your Chairman wishes to comment upon the remarkable attendance of the individual members of the Council. Non-attendance at stated meetings is exceptional and in practically every instance is caused by illness. I am deeply grateful to the individual Councilors for their attendance, for their earnest interest in the Society and, may I add also, for their kind consideration of the Chairman as their moderator.

The annual meeting should be one of our best conventions. This year the Chairman of Arrangements is Dr. R. C. Oldfield. He is assisted by Dr. M. M. Hoeltgen. These gentlemen have shown an unusual interest in the many details necessary to make such a convention a success. They have been present at several of our Council meetings and have made reports of progress from time to time.

The Chairman of Scientific Exhibits this year is Dr. John A. Mart and he has reported to the Council from time to time and the exhibits should be outstanding.

The innovation of releasing a synopsis of Council minutes in abstract form in the Journal continues to receive favorable comments from the membership and under these circumstances these abstracts will continue to be published.

Last year the annual meeting started on Monday instead of Tuesday, as had been the custom theretofore and this arrangement has seemed to be very satisfactory to the general membership. I have no doubt that this will become an established custom.

Attention is invited to the fact that no city outside of Chicago can furnish facilities to care for the annual meeting. This unfortunately makes for much work for the Chicago members, but there seems to be no solution of the problem at this time.

I can again compliment the various committee chairmen and their membership for faithful and efficient service to your Society. The custom established last year of having each committee report in person to the Council once each year has been continued and I believe has increased the interest and activities of committees. Too often in the past these Committees have felt that no one seemed to be interested in their activities and I am sure that by having them report to the Council from time to time that it has stimulated their interest.

It is to be noted that the Council has taken cognizance of the fact that many committees seem to overlap in their activities. This is no doubt due to the fact that there is no prescribed regulation in which it is stated what the duties and scope of activities of each Council Committee are. Arrangements are being made to have a booklet printed which will be distributed to the members of each committee in order that they may know exactly what each particular committee is supposed to do. I think this decision is long overdue.

While all seems to be serene and quiet on the "Banks of the Potomac" still insidiously the left wings of the Social Security Board continue to instigate legislative efforts to socialize medicine. Probably nothing will come of these efforts but when the votes are all counted next fall the profession must be on guard again in an aggressive way. No better method to combat these sinister activities is available than substantial donations to the National Physicians Committee.

The Committee on Medical Service and Public Relations continues to render efficient and valuable service. Too much praise cannot be given to Dr. James H. Hutton and his committee for their fine work. The firm of Lawrence C. Salter and Associates continues in the employ of the State Society as our public relations experts, the details of their work being rendered by Mr. James Leary. Mr. Leary's service to the Society continues to improve as he learns more about the activities of our particular Society. Indeed, Mr. Leary seems to be in contact with practically every department of our State Society and he has rendered invaluable service. His contacts with various industries, labor groups, women's clubs, newspapers, periodicals, etc. have certainly added to better public relations for the Society.

An outstanding activity of this committee has been a Council approved statement of principles and programs for public relations activity. I have impressed upon those County Societies and women's auxiliaries in my own District that the services of the public relations office are available to them whenever they need direction and advice in public relations problems.

Mr. Neal, the secretary of this committee, is a tireless worker and renders invaluable service to the Society. It is pleasant to know that he is now also General Counsel for the Society, replacing Mr. Rawlings who has retired because of inability to serve.

Members of the Society are urged to respond promptly and energetically to Mr. Neal's requests for aid during sessions of the legislature.

The exhibit showing the activities of the various departments of the Illinois State Medical Society continues to receive requests from various lay organizations for exhibition. This exhibit is always attended by one or two employees of the Society and they are well prepared to explain the workings of the Society not only to lay persons but to the members of the Society who seem to take most interest in this exhibit. There are various folders always available at this exhibit for distribution and it is surprising how many of these have been distributed.

The Journal Committee has had a successful year. Following the trend of the times, the cost of printing the Journal not only from a labor standpoint but from a material standpoint has increased the cost of the Journal but this is overbalanced by the increased revenue from advertising. Mr. L. E. Malley continues to be the business manager of the Journal and, as usual, is performing an efficient job.

The Journal has been severely criticized by the Editor of the American Medical Journal this year because we have steadfastly refused to be entirely dominated by the advertising agency organized by the A. M. A. Our Journal Committee feels that it is well qualified to judge as to the caliber of the products advertised in the Journal. They furthermore feel that the Editor's attack upon the advertising policies of the Journal was unwarranted. Needless to say the Chairman of the Journal Committee has the unqualified backing of the Council.

The Educational Committee is one of our busiest important committees. Under the able chairmanship of Dr. Charles Blair, assisted by his co-chairman, Dr. Warren Furey, this committee has come forward by leaps and bounds this year in service rendered to the Society. Miss Ann Fox has proved to be a very efficient secretary for this committee. I have nothing but praise for this committee.

Under the able chairmanship of Dr. Robert Berghoff, the Committee on Scientific Service and the Postgraduate Committee have held eleven postgraduate meetings throughout various areas of the State. This is the largest number of meetings ever held. Favorable comments from all over the State indicate the popularity of the postgraduate meetings. These committees have served 50 County Societies so far as programs are concerned and approximately 100 speakers have been provided for such meetings.

As you all know, the Illinois State Medical Society for some time past has maintained Chicago headquarters at 30 North Michigan. These offices are headquarters of all of the various committees, but particularly for the Scientific Service Committee and the Educational Committee, and also for the Editor and business manager of the Journal. These are the Chicago headquarters of the State Society and every member should feel free to drop in there at any time for advice and information.

Attention is directed to the building project of the Chicago Medical Society creating a society headquarters at the West Side Medical Center. It has been stated that room will be available for offices of the Illinois State Medical Society in this building.

We have had interesting and constructive reports from the Chairmen of the Committees on Cancer Control, on Medical Education and Hospitals, Child Health and on Maternal and Child Welfare.

This year the Committee on Maternal and Child Welfare has instituted an activity which should be a very constructive program for those interested in obstetrics. It is proposed to analyze each maternal death in the State. The results of these analyses will be kept under lock and key in the Chicago office of the State Society and will not be available to anyone except by permission from the Council. Reports of these analyses will be sent to those who are concerned with the individual cases.

The Committee on Medical Benevolence still feels that they have not had the proper support from the general profession for their worthwhile activity. Dr. Oscar Hawkinson has worked untiringly to create a foundation fund that will provide income to meet the

demands for relief to our deserving physicians and their dependents. The response has been quite meager. The Committee acknowledges with thanks the contributions made to this fund by the Woman's Auxiliary, this being one of their major projects. There has been considerable agitation among the membership that there should be a deduction from the annual dues from each member, payments to be put into this Benevolence Fund. That was discussed at the last meeting of the House of Delegates and no doubt will again be mentioned during this convention.

Excellent progress by the Woman's Auxiliary is being made with their major projects; extension of membership and branches and assistance to the Benevolence Fund. Satisfactory arrangements have been concluded to take care of their annual meeting budget so that embarrassing situations will not recur.

I am pleased to report that the Fifty Year Club is flourishing. It is indeed gratifying to see that doctors are participating in the increased longevity that is prevalent at the present time among the general population. The number of members in the Fifty Year Club has increased to approximately 350. As Councilor of my own individual District it has been a great pleasure for me to be present at a number of celebrations of Fifty Year Clubs in various county societies, at which in one instance, as many as seven members were inducted in one county society. Of course the annual luncheon of this group at the convention will be continued.

A Committee on Medical History with Dr. David J. Davis as permanent Historian is now activated and will be assisted by our assistant to the Society Secretary, Mrs. Frances Zimmer.

Dr. Percy Hopkins, Chairman of the Advisory Committee to the Veterans Administration, has reported concerning these activities during the year and while the medical head of the Veterans' Bureau criticized the profession generally for unethical practices, we were able to receive an apology from him in which he stated that he knew that there were only a few isolated instances of reprehensible practices. It might be well to state here that there have been only two in the State of Illinois and they were in no way due to dishonesty on the part of any of our members.

Our old contract with the Veterans' Bureau has expired but continues to operate until the Bureau sends to us the new contract which the Council has authorized its officers to sign. Few changes have been made and they are not worthy of comment. The Regional Director, Dr. Cockrell, still continues to be cooperative and I am sure has the interest of both the veterans and the physicians of the State in mind.

The Medical Advisory Committee to the Illinois Public Aid Commission has had regular meetings with the Commission and their relations with the organization are quite satisfactory. We have been able to raise a number of fees for certain types of services and as an ex officio member of that committee I am glad to report that this program is functioning smoothly.

The success of this permanent program of Government depends upon medical cooperation, especially that rendered by the county medical advisory committees. The program is here to stay and I am glad to state that thus far the profession has been given considerable latitude in planning the medical program. We have secured better fees for the doctors and I have no criticism of the entire program.

We note with regret the resignation of Mr. Raymond M. Hilliard as Director of the Illinois Public Aid Commission. He has long been a friend of the profession and we feel quite sure that his successor will cooperate with us in just the same manner.

Dr. J. H. Chivers, the Chairman of the Committee on Industrial Health, has made an extensive report to our Society on the activities of his committee and as a representative of the Illinois State Society has represented us at the National Conference on Industrial Health. This is an important committee and it has done a good job.

Last year your Chairman stated that the Committee on Voluntary Prepayment Medical Care Plans was not completely satisfied with the progress they had made. It was felt this year, with the latitude of the authority given to this committee by the House of Delegates, that the committee would be able to make more satisfactory arrangements with large insurance companies to carry this type of insurance. There have been numerous meetings with representatives of all the large insurance companies of the country. They have not as yet agreed to put out a standard type of policy for the State Society, principally because our committee was not willing to set an income level for the purchase of this insurance and were not willing to agree that the payments rendered by the insurance companies would be in full satisfaction for services rendered. However, there are a great many more policies in effect than last year and the committee is able to report progress. I think the committee should be continued for there is much work to do.

The Director of Public Health, Dr. Roland R. Cross, still continues to show the same cooperative spirit with our State Society as in the past. The Chairman of your Council made the mistake in his report last year in stating that he considered the Director of Public Health almost a member of the Council. Dr. Cross does not attend any of the Council meetings except by special invitation, but during the past year he has received a special invitation to every Council meeting and, without exception, has given us reports that were worthwhile. Never in the history of our Society has there been better public relations with the Department of Health and the governmental administration at Springfield than at the present time.

Codification and abstracts of all State laws concerning medical matters is being undertaken by Mr. Neal. This will probably become a department in the Journal or may be in the form of a published pamphlet.

The Committee on Rural Health has done an outstanding piece of work so far as public relations has been concerned. I know of nothing that has created

more favorable comment generally than the attitude of our State Society in the proposal to furnish funds for worthy young men to study medicine. Definite arrangements have been made with the Illinois Agricultural Association and when and if we have applicants for loans from this fund the program is set up. Dr. Harlan English continues to be the Chairman of this Committee with Dr. E. S. Hamilton and Dr. Everett P. Coleman assisting.

The outstanding accomplishment of the past year by this committee has been to place Illinois as the first medical society to cooperate with a large number of farm families through the Illinois Agricultural Association in the mutual solution of their health and medical problems. This activity of our Society has attracted nation-wide comment not only in medical literature but in the public press.

Dr. Oscar Hawkinson, as Chairman of the Committee on Medical Testimony, reports definite progress. As Chairman of the Medico-Legal Committee he reports cooperative activity on the part of all the members of his committee.

The Medical Economics Committee under the chairmanship of Dr. C. C. Maher, in its last annual report was discouraged because of lack of cooperation. This year the editorials by the committee have been outstanding—so that I am sure the previous pessimism is replaced now by an optimistic outlook.

The financial condition of the Society is worthy of comment. There is less surplus this year then last year but our increased expenses are entirely due to the present trend in prices, wages, and salaries. However, the financial condition of this Society still remains sound and I am sure that the Chairman of the Finance Committee is well satisfied.

This year the Society had an all-day round-up meeting of presidents and secretaries of the County Societies at Peoria, Illinois, on Sunday, 14th March, 1948. This was a very diversified program and was intended to acquaint the officers of the various County Societies with the activities of the State Society. It really amounted to a question and answer program and I am pleased to report that I have heard many favorable comments that this meeting was one of the best services we have rendered the County Societies. Certainly this should be an annual affair.

A Public Health Conference on Nutrition was held in Chicago, 1 October, 1947, in cooperation with the Chicago Medical Societies. A committee of Dr. G. C. Otrich and Dr. John O'Neil, a former vice president, was appointed by the chair to cooperate with this project. A report from that committee which appears elsewhere indicates that this national movement on nutrition is to pay attention to an otherwise neglected and important question.

An important committee, the Veterans Service Committee, has had its name changed to meet with the recommendations of the American Medical Association Council on National Emergency Medical Service, so that, at the present time, the old committee is now known as the Committee on Military Affairs and Emergency Medical Service. This supplants the old Veterans Service Committee and in the event of a national emergency should be able to render the service requested by the American Medical Association.

Finally, I repeat what was stated last year. I feel that the Illinois State Medical Society has had a constructive year. I am again deeply indepted to the various committee members for their committee work. I realize more than ever how much time these committee members expend in their attendance at these committee meetings and to them I wish to extend the thanks of the entire Illinois State Medical Society. Our Secretary, Dr. Harold M. Camp, continues to be as efficient as he has always been. I marvel sometimes how much he is able to accomplish and how much he knows about all of the details of the administration of the Illinois State Medical Society. I am personally indebted to him for his cooperative help. I wish to extend our thanks and appreciation for his services. How he is able to to get around to the various meetings and still continues to keep his fingers in touch with every detail of the Society is more than I can comprehend.

May I again say that it has been a pleasure and an honor to have been Chairman of the Council for two years and I am deeply and humbly greatful.

Respectfully Submitted,
Walter Stevenson, M. D.,
Chairman of The Council.

REPORT OF THE COUNCILOR OF THE FIRST DISTRICT

To The Members of The House of Delegates:

As usual at this time of the year it is necessary to report to the Society as to the conditions in the District.

The First District is in good condition and so far as I know all Societies are functioning,—perhaps not as actively as is possible, but due to local conditions and topography it is not possible to be as active as some other Societies with less distance to travel and a more concentrated membership.

We have had a very successful year in the District. Last October we had a very successful Postgraduate meeting at Rockford with a very good program and a well attended meeting. This past February we again had a very interesting and instructive district meeting in Elgin on Cancer. This meeting was well attended for the roads and weather conditions at that time.

We have presented four 50-year emblems this year—one to Dr. R. G. Scott of Geneva, one to Dr. Rice of Mt. Carroll, one to Dr. Schreiter of Savanna, and one to Dr. John Asher of Freeport.

The local Societies are doing quite well and many of them are picking up a number of new members with the return of men from the services.

All told, the First District is in good condition.

Respectfully submitted,
L. J. Hughes, M. D.,
Councilor First District

REPORT OF THE COUNCILOR OF THE SECOND DISTRICT

To The Members of The House of Delegates:

The following is a brief report on the activities of the Second Councilor District.

During the past year, the usual number of meetings were held with an average attendance. There were no outstanding activities except for a postgraduate conference held at Princeton on December 5th, 1947. This meeting proved to be a very interesting one with a little more than average attendance. In your councilor's absence, Dr. Davies of Spring Valley had charge of the meeting.

The second meeting for the year was held at the Kaskaskia Hotel, LaSalle, Illinois, April 8th, 1948, which was a symposium on cancer. This was sponsored by the Second District of the Illinois State Medical Society and the Illinois Division of the American Cancer Society, Inc. This Program covered a wide range of subjects and proved to be a very profitable meeting. Dr. Roswell T. Pettit had charge of the meeting.

There were no unusual incidents during the year throughout the District, excepting Dr. Frank W. Broderick of Sterling was honored by being presented with a fifty-year pin.

Respectfully submitted,

H. L. Pettitt, M. D.,

Councilor Second District.

REPORT OR THE COUNCILORS OF THE THIRD DISTRICT

To The Members of The House of Delegates:

The Third District has for its constituency nearly six thousand five hundred doctors who, in fifteen branch Societies, constitute The Chicago Medical Society, the Medical Society of Cook County.

Monthly scientific and business meetings were held by each of the component branch societies and by the Central Society. The meetings of the individual branch societies were usually held as combined business and scientific sessions. In the Central Society the scientific meetings were held apart from those at which the business of the society was transacted. The nineteen specialty groups in this area have also presented excellent scientific meetings.

The Postgraduate Courses sponsored by the Chicago Medical Society were enthusiastically received by a completely filled registration and announcement has been made of a new series of a similar nature.

The facilities and medical personnel in the Third District have greatly aided the postgraduate work in the field of cancer study by the joint efforts of the Illinois Division of the American Cancer Society and the Illinois State Medical Society.

The fourth annual Chicago Medical Clinical Conference was held at the Palmer House on March 2, 3, 4 and 5 under the dynamic guidance of Doctor J. J. Moore. Thirty-five scientific papers were delivered, two clinico-pathologic conferences were conducted and panels on "What's New in Medicine and Surgery" and on "Obstetrics" were presented. Of the nearly 4,800 registrants slightly less than 3,000 were physicians, almost 1,000 of whom came from 30 different states and 9 foreign countries. There were 47 outstanding medical authorities from the United States and Canada on the speakers program. Great interest was shown in the 22 excellent scientific exhibits. The technical exhibit hall was filled with the presentations of 101 commercial firms.

"This Week in Chicago Medicine" began publication since the last annual report. Each week the Chicago Medical Society lists in this bulletin the activities of the medical schools, hospitals, clinics and scientific meetings of medical groups for the convenience of visiting and local physicians, who are interested in attending programs of educational value. Its reception has been most enthusiastic and its circulation is rapidly increasing due to requests from other medical societies and from hotels which recognize its value to physicians who visit Chicago.

The Chicago Medical Service Plan for prepayment for medical care has been approved by the State Insurance Commissioner. The directors have been appointed and the administrative organization has been completed. Several thousands of clients have shown a desire to participate in this plan, which is sponsored by The Chicago Medical Society and administered by Blue Cross. It is believed that approximately ten thousand policies will be in effect by the time this report is presented to this House of Delegates. This culmination of years of work on the part of the Committee for Prepayment Plans should, to quote from our report of last year, "be another step toward voluntary prepayment for (medical) services and away from the pauperizing pernicious political plan proposed by the proponents of the Federal government."

A permanent home for the Chicago Medical Society is a subject arousing renewed interest and greater activity. Most of the membership realizes that after one hundred years of "rooming around" with the continued accumulation of valuable records and ever-increasing activities a permanent headquarters should be established, one which would identify the organization as a part of the world's greatest medical community. There has been a plan for many years to use a treasury surplus for this purpose, and now, due to the conservative measures of an efficient Board of Trustees this amount has attained a sizeable figure. The Permanent Home Committee, after many years of study and planning, has made an authorized contract with the Chicago Medical Commission to purchase a parcel of land in the Chicago Medical Center for a building site. This location is an ideal one with ample parking facilities. The methods of securing the additional funds necessary for the completion of this project have included a a study of an increase in dues, a popular subscription, and a special assessment.

Our president, W. W. Furey, is Chairman of the Committee for General Arangements for the Annual Meeting of the American Medical Association to be held in Chicago in June. Under his leadership this County Medical Society is striving to make this

another of the great medical events for which Chicago has become famous.

It has been a great pleasure for we Councilors to serve The Chicago Medical Society and a distinct privilege to meet with the Councilors of the other districts under the pleasantly efficient and capable leadership of Walter Stevenson, Chairman of the Council.

Respectfully submitted,

Oscar Hawkinson, M. D., Harry M. Hedge, M. D., Leo P. A. Sweeney, M. D., H. Prather Saunders, M. D., Wade C. Harker, M. D., Darwin B. Pond, M. D.,

Councilors Third District.

REPORT OF THE COUNCILOR OF THE FOURTH DISTRICT

To The Members of The House of Delegates:

It is the duty and pleasure of this Councilor to report to you that the affairs of the Fourth District are progressing quite smoothly insofar as the scientific practice of medicine is concerned and also in the realm of Economics of Medicine. The District as a whole is better "staffed" than it was a year ago. Problems of conduct of a local nature have arisen and have been solved. Disapproval of the relationship between the physicians and governmental agencies in some communities have been voiced and have generated some friction. The acquirement of information of facts by the local physicians concerning the policies underlying such relationships has smoothed out this friction.

It has been the intent and activity of this Councilor to keep the Constituent Societies of the Fourth District acquainted with, and informed, concerning the various projects of the Illinois State Medical Society. These component Societies (10) have been more active this year in the meetings held, and their scientific programs have been excellent. The attendance at these meetings for the most part has been beyond what had been expected. Many of these Societies now have men returned from military service in charge of the activities of the organizations as officers. The interests of these younger men in their society problems and programs is very commendable indeed. Most of the County Societies have taken an active part by means of the guided effort of individual members in initiating or steering the activities of local lay organizations whose programs touch or actually stage projects of a medical nature. It is hoped that the potentiality of this particular phase will be recognized and that ultimately all organizations will look to the physicians for guidance in whatever work they put forth that deals with public health or with the medical care of their community.

Your Councilor wishes to express his sincere thanks to the officers and members of the various component Societies for their support and cooperation during the past year. He hopes they, as well as the entire membership, will continue their interest in scientific and economic problems of medicine.

Respectfully submitted,

Charles P. Blair, M. D.,

Councilor Fourth District.

REPORT OF THE COUNCILOR OF THE FIFTH DISTRICT

To The Members of The House of Delegates:

In medical practice normal conditions now prevail but noticeable changes have occurred following the war. The various county societies appear to be in a satisfactory condition and the membership has never been as large as at present. Meetings have been held regularly and the attendance has been good, except in some of the smaller societies where it is difficult to get the members out for meetings. More of the young men are going into special lines of work.

Probably there has never been a time when good leadership in the local societies is so essential as at present. A good many people are critical of the medical profession and if we are to maintain the confidence of the public, physicians must be willing to give more time to community service and not confine all their efforts to personal business.

The response to the appeal of the Benevolence Committee for contributions to an endowment fund has not been good. Certainly the profession should be interested in giving assistance to those disabled or retired who have been unfortunate in financial matters. A request for $100,000.00 for this purpose is not unreasonable to ask from a society with almost 10,000 members.

Three counties in the District have recently established health departments. With proper leadership these county units can be of great help both to the profession and the citizens of the county. One of the most important members of the county unit staff is the health educator. If she is capable and well trained she can be of great assistance in instructing the public in matters of health. The public is willing and eager for the instruction which a good health educator can give.

The establishment of County Health Councils can do much to mold opinion in matters of health. McLean and Montgomery are the only counties in the Fifth District which have health councils. In McLean County this was organized ten years ago largely through the efforts of a member of the local medical society. It has worked quietly and without much publicity. It was this organization which took the initiative and was instrumental in the creation of the county health unit. Organizations of this kind should be encouraged by the profession in various counties. Recently the American Medical Association has recommended such action.

The committee on rural health is doing commendable work in helping to solve some of the problems of medical service in the rural areas. On recommendation of this committee the State Society is now cooperating with the Illinois Agricultural Association in helping to finance prospective medical students from rural communities.

During the past year a number of deaths have occurred in the district. In Sangamon County Dr. S. E. Munson, former Councilor and later President of the

State Society, pased away. Recently Dr. Harry Otten, a delegate from Springfield died following an accident. In McLean County Drs. A. W. Meyer, E. M. Minnick, and Ernest Goldman have died.

Last October a postgraduate conference was held in Lincoln with a good program. The attendance was not large because of conflicts with programs in adjoining counties.

Respectfully submitted,
Ralph P. Peairs, M. D.,
Councilor Fourth District.

REPORT OF THE COUNCILOR OF THE SIXTH DISTRICT

To The Members of The House of Delegates:

All County Societies in this District are functioning well. Meetings are held regularly, are well attended and the programs seem satisfactory.

With one exception every Society has been visited by the Councilor; some have been visited twice.

The Fifty Year Club has had many additions during the year in this District. One Society inducted seven new members at one session. Another will add three members in April. It is gratifying to observe the genuine enthusiasm displayed at these meetings by the newly inducted members of the Club and to note the spirit of the regular Society members in their efforts to honor those physicians who have served so faithfully during the long period of 50 years.

One excellent Postgraduate meeting was held at Jacksonville with a very large attendance and a well balanced program. We appreciate these meetings and the Districts only comment is that they wish they could have more of them.

There has been no evidence of any local disagreements of any sort which required consultation with the Councilor.

The Councilor is grateful for the fine spirit of cooperation shown by the constituent societies of the District and has been proud to be their representative.

Walter Stevenson, M. D.,
Councilor Sixth District.

REPORT OF THE COUNCILOR OF THE SEVENTH DISTRICT

To The Members of The House of Delegates:

It is a pleasure to report that the component Societies of the Seventh District are in excellent shape, they are active and most of them have regular monthly meetings.

The following counties have established active county health units during the past year: Effingham, Piatt, and Shelby.

Macon County Society developed during the year a Cancer Clinic at Decatur and is doing a great work.

The outstanding activity in the district this year was the postgraduate work. Effingham County Society was host to the first Postgraduate Conference and entertained at Effingham in October. The speakers were outstanding and the program excellent It was well received by an attendance of near one hundred.

March 25, 1948, Macon County was host to the second Postgraduate Conference and entertained at Decatur. Being out of the State on this day it was my misfortune to miss this conference. Reports coming in from those who were in attendance gave praise to the high class program and the perfect host the Macon County Society proved to be.

Respectfully submitted,
C. H. Hulick, M. D.,
Councilor Seventh District.

REPORT OF THE COUNCILOR OF THE EIGHTH DISTRICT

To The Members Of The House Of Delegates:

The Eighth District medical affairs have been conducted on a relatively high plane for the past year. Probably the most troublesome problem has to do with the control of and charges made for the care of chronic, complaining patients on the public assistance programs. The counties having active advisory committees have little trouble with the doctors of their society. Counties who do nothing and have a nonfunctioning (except on paper) advisory committee have troubles. Very few areas in the District are in need of any new medical personnel. Group practices have been started in a few towns in the District during the past year. No hospital construction of any size has been done. Special elections to establish hospital authorities are in the process of being developed. High incomes and increasing insurance protection has made hospital bed occupancy nearly 100 percent at all times.

Virtually all active societies were visited during the past year. An effort was made to have three scientific meetings in the south half of the District and comprising five small (in number of members) county societies. The trial was not satisfactory and we will continue to try combined meetings next year.

Respectfully submitted,
Harlan English, M. D.,
Councilor Eighth District

REPORT OF THE COUNCILOR OF THE NINTH DISTRICT

To The Members Of The House Of Delegates:

It is our pleasure to report at this time that the component Societies of the District are in excellent shape, each county, with the exception of two whose membership is too small to carry on an active organization, has an active County Society with regular meetings. I have attended several of the various county meetings, and find they have good programs, with good attendance, and are greatly interested in the work of organized medicine. The officers of the component societies are very cooperative.

The outstanding activity in the District during the past year was a Postgraduate Conference at Marion,

Illinois, in October. There was an excellent program with good speakers, all from Chicago, with an attendance of some fifty or sixty physicians and there should have been more. There was an excellent all day meeting at Herrin in May, a Cancer Symposium, with a clinic program. There was material galore from Herrin and surrounding towns. The speakers were outstanding men from Chicago. The interest and attendance was great. We are to have another meeting this year, of the same type, at the same place on May 20.

Our Southern Illinois Medical Association met last November in Belleville. There was a fine program and a large attendance from the Ninth District. The annual meeting is to be held in Benton this year on November 4.

The Six County Medical Society was entertained four times during the year by Franklin and Williamson Counties. There was great interest manifested at these meetings and the physicians are very enthusiastic concerning this organization. It is my opinion that this organization is doing a great deal of good for organized medicine.

It has been a pleasure to serve as a Councilor of the Ninth District and to be associated with the members of the Council.

Respectfully submitted,
C. O. Lane, M. D.,
Councilor Ninth District.

REPORT OF THE COUNCILOR OF THE TENTH DISTRICT

To The Members Of The House Of Delegates:

The progress of medicine is dependent upon the progress of the members of its organizations. Organized medicine starts with the County unit and without an active county unit the foundation of the whole structure is weak. With the exception of a few, the Tenth District has very active County Medical Societies.

The Postgraduate Conference, which was held in Murphysboro, was attended by about 60 despite the weather. Snow and ice covered the highways and traveling was almost impossible. Jackson County is to be complimented for the way this meeting was handled.

The Southern Illinois Medical Society held its annual meeting at Belleville and was considered one of the best in its history with an attendance of 150.

The Six-County group in Southern Illinois is still functioning in a very superior way, the average monthly attendance being 60-90.

A meeting of the Illinois Heart Association (southern section) sponsored by the St. Clair County Medical Society held in East St. Louis was most outstanding and educational.

I wish to express appreciation of the doctors in the Tenth District to the various committees of the State Society which made it possible for the speakers at these meetings. Some of our County Societies are arranging meetings with the Farm Bureaus in their respective counties and I believe before the year is over there will be more such meetings held.

There are several hospital projects in the making in the district which, as the survey shows, are in dire need. We have had quite an influx of young doctors but there is still need for more in the southern section of the state.

A number of 50-year certficates and buttons have been presented the past year, which speaks well for the hardihood of the old-timers.

This is election year and I urge every doctor not only in this district but over the entire state to forget their petty politics and get out and work and vote for the candidate who might make it possible for you to practice medicine as a free man.

I wish to express my appreciation to the officers and members of our County Medical Societies who have made the success of our organization possible during the past year.

Respectfully submitted,
G. C. Otrich, M. D.,
Councilor Tenth District.

REPORT OF THE COUNCILOR OF THE ELEVENTH DISTRICT

To The Members Of The House Of Delegates:

Organized medicine in this district is in excellent shape. All Component County Societies are well organized, have capable officers and with regular meetings, the membership is showing great interest.

The influx of the young members of the profession, locating in the rural areas mostly, now adequately staffs them to give competent service throughout the district. The reception of the new physicians by the older members of the profession has been most kind and they are working together nicely.

The annual Postgraduate Meeting was held in Kankakee, April first. The meeting was excellent due to the interest and enthusiasm of the membership. An effort is made in this district to hold the Postgraduate Meeting in different parts of the district and the program in the hands of the host Society. The Kankakee Society outdid itself in entertaining at the past meeting.

Your Councilor has attended as many meetings of the Council as possible. Your Councilor continues to be active in the committee work on the following: Medical Service and Public Relations, Medical Care Public Assistance Recipients, the committee on Prepayment Medical Plans. All these committees are very active and take considerable time.

Your Councilor wishes to express thanks to the officers of the Component County Societies for their cooperation, the Officers of the State Society, and especially to the office of the Secretary for their assistance.

Respectfully submitted,
E. S. Hamilton, M. D.,
Councilor Eleventh District,

REPORTS OF COUNCILORS AT LARGE

To The Members Of The House Of Delegates:

It is my privilege herewith to report to you as Councilor at Large those activities which are of importance and interest to the House of Delegates and to the membership at large as follows:

(1) In May of 1947, immediately after the expiration of my term as President of the Illinois State Medical Society, the Honorable Martin H. Kennelly, Mayor of the City of Chicago, deemed it wise and necessary to have on the Board of Education for the City of Chicago a member of the medical profession. Accordingly, at that time, he tendered me a five year appointment to the Board which I accepted.

Already several matters of considerable importance to the medical profession have come before the Board of Education and it has been my pleasure to champion both of them. The first had to do with visual screening of school children, which, as the state law provides, should be carried on "by a physician or under the direction of a physician." This matter I reported favorably to the Board and to the Superintendent of Schools, Dr. Herold Hunt. The second matter which concerns the medical profession has to do with the physical examination of school children demanded by law every four years. The details of these recommendations brought to me by the proper Committees of the Chicago and Illinois State Medical Societies I also brought to the attention of the Board of Education.

(2) Three years ago Governor Dwight H. Green appointed me chairman of a committee to aid him in selecting the site for a proposed 600 bed tuberculosis hospital to be built within the County of Cook for which monies had been allocated by the legislature. At that time we considered a site in the southern section of the City of Chicago. After mature consideration and deliberation it was quite apparent that, for many reasons, this location would have proven impractical. Accordingly, a few months ago, the Governor again appointed a committee of which I was a member and at a memorable meeting with the commissioners of the Medical Center in Chicago the Governor selected a ten acre site in this area. The first state-built, operated and maintained tuberculosis sanatorium will be erected on this site in the very near future and will have a capacity of 600 beds.

It is a pleasure to report this progressive step toward the control of tuberculosis—statewide.

(3) It has been my pleasure during the present year to attend practically all of the Council meetings and I reiterate, as I said in previous reports as President-Elect and President of this State Medical Society, that I have the highest regard for the efficiency and wisdom of this body, individually and collectively.

In conclusion, I wish to express my sincere appreciation to His Excellency, the Honorable Dwight H. Green, Governor of Illinois, and to his Director of Public Health, Dr. Roland R. Cross, for the complete and unique cooperation accorded the organized medical profession of the State of Illinois.

In my opinion no other state in the United States can claim this close relationship with the Governor.

Accordingly, I should like to recommend, and do, to the House of Delegates that the Secretary of the Illinois State Medical Society be instructed to transmit to His Excellency, the Governor of Illinois, these sentiments of appreciation coming from the House of Delegates.

Respectfully submitted,
Robert S. Berghoff, M. D.,
Councilor at Large.

To the Members of The House of Delegates:

As Councilor at Large, without the local responsibilities that formerly existed, it is possible to note with interest several of the general problems of the profession as applied to the state.

Your Councilor at Large has attended all the meetings of the Council, as well as the meetings of the various committees to which he has been assigned. The reports of two of these committees are published in this list of annual reports. Several things appear to be of outstanding importance. One is the importance of working with the state groups, whether legislative or other special groups, such as our own. Our relations with the Illinois Department of Public Assistance have been very satisfactory and it is felt that while many problems in this line have not been satisfactorily solved, the interests of the profession as well as the public have been protected to a greater degree than might have been thought possible a few years ago when this relationship was first opened up. Our connections with the Illinois Agricultural Association seem to be on a firmer basis than ever before and we find in this group individuals who think, talk, and act as we do. They are certainly the reverse of the theorists who are so inclined to interfere with the practice of medicine to its detriment, and we should continue to improve our relationship with the farmers who, in the middle west, are the backbone of the nation and the ones who continue to think in the terms of Americanism rather than Internationalism.

As a member of the Advisory Board to the Division of Cancer Control, and working with the Illinois Division of the American Cancer Society, it is noted that the work of the Cancer Society and the legislative program directed towards the control of cancer have been kept within reasonable bounds, largely by sensible, sound medical advice. This is a program with an emotional appeal equal to that of infantile paralysis, and just as easily subject to abuse and to lay exploitation. The fact that medical men have taken the time and trouble to give proper advise to the lay groups who are interested and to control the activities of this work indicate that the public will receive "value received" for the funds they have contributed, and that the work of the local cancer committee in the various hospitals over the state will go a long way towards helping solve many of the local problems of this particular disease. While it is perhaps not too desirable to have undue emphasis placed on some one disease and then have that subject to too much legislative inter-

ference, it is felt that the way this particular problem has been managed is beneficial to all parties concerned, and that the medical profession will continue to benefit from such association, but only as long as it furnishes the leadership which it alone is able to contribute.

As was reported last year, the Commission on Hospital and Medical Care was able to recommend a bill to the State Legislature quite different from that which had been originally introduced. The original one was a little Wagner-Murray-Dingell bill. The commission, after nearly two years of study, recommended a bill which would tend to correct some of the deficiencies in legislation that had already been passed and not to bring in the undesirable features of a little Wagner-Murray-Dingell bill in Illinois. It was felt that quite a little had been accomplished in making this much progress, but the projected bill also was lost in the last minute rush of legislation at the final session of the legislature. Perhaps, as being a way to avoid certain undesirable features of legislation, this last minute rush may have some merit.

Members of the Council have had to have certain contacts with national legislative problems and with the change in Congress the past election, some of our more urgent problems have been temporarily sidetracked. However, so long as the present administration stays in power, the individuals who are spending full time and who have spent over eighty million dollars in propaganda, which Senator Harness feels has been spent illegally, for the purpose of propagandizing compulsory medical legislation, these problems are only temporarily laid aside and we will have to face them as soon as another session of Congress is held. It is felt that if the administration is changed at the next election, most of our problems in that respect will be put aside for years to come and perhaps permanently. If it is not changed, we may be faced with a still more difficult fight in self-defense. The importance of backing up the American Medical Association and also the National Physicians' Committee cannot be overemphasized.

In conclusion, it might be well to state that those of us who have followed the Shearon Medical Legislative Service from Washington have been given a remarkable opportunity of observing the why and wherefore of anti-medical legislation originating in Washington, as well as the aims and objectives of the personalities involved.

Respectfully submitted,
Everett P. Coleman, M.D.,
Councilor at Large.

REPORT OF THE EDITOR

To The Members Of The House Of Delegates:

Although there are still many problems which have to be encountered each month in regard to publishing the Illinois Medical Journal, conditions in general have improved considerably during the past fiscal year. We are now able to have the Journal in the mail for the current month by the 20th, and sometimes a few days earlier. There is still a paper shortage, and we are buying our paper in advance so that there will be no difficulties in that regard at the last moment.

The Journal Committee and the Editorial Board have held joint meetings at fairly regular intervals, and have given serious consideration to the many problems in connection with the publication of a satisfactory medical journal. The Journal Committee is responsible for the acceptance of advertisements and more consideration has been given in recent years than previously on this important subject.

Our records show that during the past two years the committee has refused to approve advertisements, which would have brought in an additional $12,000.00 in advertising revenue, but as has been repeatedly stated in our annual reports, the main function of the Illinois Medical Journal is not to see how much advertising income may be produced, but to do everything possible to give the membership of the society the type of journal which will be of most benefit to them in their work.

We have enlarged the "News of the State" section, and are glad to receive notices of medical meetings, names of speakers, subjects, and other information which is really news of the state from a medical standpoint.

The awarding of prizes for the best articles in the two designated classes required a considerable amount of effort on the part of the Editorial Board and Journal Committee, and in one of the two classes, it was deemed advisable to award duplicate prizes, as was mentioned in the Journal. This apparently has been an additional stimulus to many of our authors to present articles on subjects of more interest to the profession as a whole, and articles which have been more carefully prepared to increase their attractiveness as well as their interest. The Council authorized the continuance of these awards, making it an annual affair. As we stated one year ago in the annual report, these two classes are:

1. For the best written article passed upon by literary and scientific people, and

2. For the outstanding piece of original work as presented in a paper.

For the first class a cash award of $100.00 is made, and for the second class an award of $200.00, this to apply to original scientific articles and scientific editorials.

We have recently added another section to the Journal content, headed "Medico-Legal Briefs," in which questions on various medico-legal problems may appear and the answers published. The first questions received were relative to the duties of coroners, and the answer required some six or more weeks for an accurate answer, owing to the wording of the Illinois laws regarding coroners and their duties. Mr. John W. Neal, as General Counsel for the Society, has volunteered to give the answer to medico-legal questions, and we have the assurance that questions pertaining to governmental services, such as functions under the State Department of Public Health, Medical

Care, as a responsibility of the Illinois Public Aid Commission, or Department of Public Welfare, will be answered by some official of these respective departments. The American Medical Association likewise has given assurance that members of their staff will be happy to have questions referred to them, especially if concerning functions and duties of medical organizations, or some special field in medicine for which they have an official Council or Bureau.

The Editor of the Journal of the American Medical Association recently published an editorial relative to the Cooperative Medical Advertising Bureau, which has been under their supervision since its organization in 1913 to aid the state medical journals in securing acceptable advertisements. The Editorial criticized the Illinois Medical Journal, and the journals of three other state societies which are not members of their "C. M. A. B." and the Illinois Medical Journal came in for more criticism than the others, in that it was never a "C. M. A. B." member.

At the order of the Council, an answer to this editorial appeared in the April, 1948 Illinois Medical Journal, the editorial having been submitted to and approved by the Council prior to its publication. The use of the terms "approved; unapproved; scientific and unscientific products" has been definitely confusing, in that according to the editorial in the J. A. M. A., acceptance by the Council on Pharmacy and Chemistry, virtually changes a product from an unapproved to an approved product, and obviously from an unscientific to a scientific product.

The Journal Committee being entirely responsible for acceptance of advertisements in our Journal, has given serious consideration to these problems, and proposes to once more give thorough consideration to all advertisements appearing in the Illinois Medical Journal, and will be most critical of their acceptance of new contracts in the future. Their actions are subject to approval of the Council, which body under the By-Laws is solely responsible for the publication of the Journal.

The Illinois Medical Journal being the official journal of the Illinois State Medical Society, through those delegated the responsibility for its appearance each month, is desirous of publishing what the membership as a whole desires. It is your Journal, and should express your opinion as to any suggestions which may improve the Journal at any time. It is the desire of the Council, as well as the Editorial Board, Journal Committee and the Editor, to know what you think of your Journal, and to receive either criticisms, or words of approval for their efforts.

The Editor once more desires to pay his respects to Mr. L. E. Malley, who has acted as Business Manager for the Journal during the past seven or more years. He is intensely interested in the Illinois Medical Journal, and in carrying out the desires of those responsible for its publication. He is in charge of all business matters relative to advertisements, making up the dummy, and assists materially in the proof reading each month. Mr. Malley attends all of the joint meetings of the Journal Committee and the Editorial Board, and is always anxious to receive definite instructions as to his duties and responsibilities.

Likewise it is our desire to again thank the members of the Journal Committee and Editorial Board for their assistance and encouragement, for without this help it would indeed be a herculean task to assume the many additional responsibilities which would be ours.

As has been repeatedly stated before, those of us interested in the publishing of the Illinois Medical Journal are ever desirous of receiving any suggestions from the House of Delegates pertaining to its improvement or any suggested changes in policy.

Respectfully submitted,
Harold M. Camp, M. D.,
Editor

REPORT OF THE COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

To The Members Of The House Of Delegates:

As the name of the committee indicates, its activities intermingle with those of other committees so that it is sometimes difficult to decide where the activity of one ceases and the other begins. This is particularly true with the Educational Committee. However this is a matter of no great moment. Dr. Blair, chairman of the Educational Committee, has met with our committee regularly over the past several months while he has invited the chairman of this committee to sit in with meetings of the Educational Committee. Some activities mentioned briefly in this report will be discussed more fully in Dr. Hopkins' report of the Committee on Prepayment Plans for Medical and Surgical Care and Dr. English's report for the Committee on Rural Medical Service.

Mr. Leary's and Mr. Neal's reports of their activities are included in this in order to give the House of Delegates as complete a view as possible of the many efforts undertaken to place medicine in a more friendly relation with the other elements of this great commonwealth. Medicine has too often been maneuvered into positions where it could be charged with always being "agin something" and of having no constructive program of its own. The fact that what we are opposing was something that, for the sake of the common good, should have been defeated is beside the point. In the past few years we have gotton out of that position and now have three major definite constructive programs which are designed to benefit all the people of Illinois and which consequently enlist the support of large numbers of people. Two of these are carried out by other committees.

Dr. Hopkins and his Committee on Prepayment Plans for Medical and Surgical Care have developed plans whereby people can, for extremely moderate fees, insure themselves against the cost of catastrophic illness. This span is cheaper and more effective than the cumbersome compulsory plan proposed by the federal bureaucrats.

One of the new cries of the federal do-gooders is that rural communities are sadly in need of physicians. Dr. English and his Committee on Rural Medicine have brought the Society and the Illinois Agricultural Association together to set up a loan fund to meet the need for more physicians in smaller communities.

The third is the effort to eradicate tuberculosis as a major public health hazard. Work in connection with this project has consumed a great deal of time on the part of Mr. Neal, Mr. Leary and the chairman. This program has brought us into pleasant cooperative relations with about 75 non-medical groups including the various divisions of labor.

When the House of Delegates met last year the fate of our legislative program presented to the 65th General Assembly was still unsettled. The program was represented by three bills. One sought to raise the pegged levy of the Municipal Tuberculosis Sanitarium from $3,000,000 to $6,000,000 per year. The legislature permitted $4,750,000 for 1947 and $4,500,000 for 1948. Another would have had the State pay to each sanitarium board $2.50 per day for each patient hospitalized at public expense. This was violently opposed by the administration and died on the calendar. The third would have appropriated $15,000,000 for the erection of tuberculosis hospitals. The legislature appropriated $850,000 each for a hospital at Savanna and one at Mt. Vernon, and $5,000,000 plus $80,000 for the acquisition of a site, for one hospital in Chicago.

It is said that Illinois pays about 8 per cent of the nation's tax bill. If that is true, Illinois sent to Greece $32,000,000 in the President's first gift of $400,000,000. The total appropriation requested to fight tuberculosis and save the lives of Illinois citizens was $24,000,000, three-fourths as much as Illinois sent to Greece via the federal government. The legislature actually appropriated to fight tuberculosis $6,780,000—only slightly more than 20 per cent as much as Illinois sent to Greece.

The subcommittee on legislation is now formulating plans to be presented to the 66th General Assembly it convenes January 1, 1949. If the campaign of public education about to be undertaken by Mrs. Velma Clark, employed by the Tuberculosis Institute of Chicago and Cook County, is successful in educating the people of Illinois to the dangers of tuberculosis and the possibilities of its practical eradication, it is believed that the state administraton will support any sensible plan presented to the legislature.

The committee wishes to express appreciation for the pleasant cooperation it has enjoyed from the officers, Councilors and other committees of the Society and to Mrs. Frances Zimmer, executive assistant to Dr. Camp, and to Miss Ann Fox, secretary of the Educational Committee.

Respectfully submitted,

James H. Hutton, M. D., Everett P. Coleman, M. D., Edwin S. Hamilton, M.D., *Committee on Medical Service and Public Relations.*

REPORT OF PUBLIC RELATIONS ACTIVITIES

The year has been one of development and expansion in the public relations program of the Illinois State Medical Society. With two years of experience on the records, it has been possible, as a most important accomplishment, to set forth with the approval of the Council a statement of principles, objectives, and program for public relations activities. This represents an important forward step. It means that after a long period of experimentation and study, the committee has been able to establish a series of broad principles to guide our effort and to define our objectives and to outline the activities by which we will seek to achieve them. It is to be hoped that during the year to come, it will be possible to interpret and apply and execute these broad statements through every part of the Society.

More specifically, the plan of operations has taken definite shape. The system of cooperation with the various officers and committees is well established. Our mailing lists have grown to nearly 1100 items. Our contacts with newspapers and radio stations and other channels of communication have been expanded and strengthened and the infinite details that go into so wide-spread a cooperative effort well worked out. At the same time, the cumulative effect of two years of continuous effort has begun to make itself felt. There is better use of our material as editors and the public become familiar with it and gain confidence in it. The services offered by the Society have won additional standing and respect. Press associations and individual newspapers turn to us with increasing frequency for information or aid in the development of news stories, even at the expense of other similar services which are available.

In this connection, the only important recommendation which seems essential is that some of the committee chairmen and officers of county societies facing specific problems or needing consultation or assistance of any sort in public relations problems should be more ready to turn to this service of the Society.

It is difficult to offer specific details indicating the expansion and development of a public relations program. Last year a total of 40 (forty) stories including some 90 (ninety) pages of mimeographed copies and 5600 pieces of mail were issued. In the year just closed the total of more than 50 (fifty) stories, amounting to well over 100 (one hundred) mimeographed pages and 9250 pieces of mail, were issued.

Last year the public relations counsel attended 88 (eighty-eight) committee meetings, mostly in Chicago, and another dozen or more out of the city, plus innumerable conferences with various individuals as part of his work for the Society. Despite the general acceptance of the five-day week, he spent ten (10) Saturdays and eleven (11) Sundays in meetings of one type or another. He has written two new editions, one representing an extensive revision and expansion of the pamphlet describing the Illinois plan for prepayment medical care insurance; a third called "Doctors and

Horses," which has proven extremely popular among those interested in rural medical care; and a fourth, the brochure for the exhibit, "The Doctor and His Society," all based on the finding that the pamphlet technique is an extremely valuable one, something which had been merely experimented with during his first year.

The problem of attendance at meetings has also expanded considerably. This year, for instance, there was the American Medical Association Centennial in Atlantic City where he spent five days, the interim A. M. A meeting at Cleveland for another five days, the numerous trips through Illinois—Monmouth, Peoria, Galesburg, Decatur, Springfield, Jacksonville—all involving from one to three days and on each of which some duty on behalf of the Society was carried out.

At the same time, distribution procedure has been worked out in greater detail. Since the majority of our communications is by mail, a great deal of time and thought has been expended on the development of mailing lists. As mentioned above, the list now available for use in the Society's work totals nearly 1100. This is broken down into various categories: Daily papers of Chicago, daily papers downstate; weekly papers of Chicago, of Cook County outside Chicago and nearby areas, weekly papers downstate; farm bureau advisors; medical journals throughout the country; science writers of the country; press associations; specialty journals, both medical and other; various columnists, such as health and nutrition; labor publications; agricultural publications; foreign language papers; Chicago radio, downstate radio, and national radio. By such divisions it is possible to select those categories to which any given release would be attractive, and by the use of all categories at once, it is possible within the space of a few days to blanket the state completely with Society material, and echo it throughout the country.

The news stories serviced for the Society have come from various sources. Originally, the principal source was the annual meeting and articles in the journal. In the last year, however, activities of the various committees and certain decisions of the Council have provided a good deal of material. The number of clippings received from the one clipping service used by the Society has produced 554 clippings in the last year. Analysis of these clippings shows that the Associated Press, the United Press, the International News Service and the North American Newspaper Alliance, have picked up a considerable number of Society releases, which means that they were distributed throughout the rest of the country in addition to Illinois. There is no method by which the extent of publication of such stories can be determined, for the clipping service covers only Illinois. However, occasional clippings which come to light by accident show that there is considerable use of these stories. At the same time, of course, it picks up a substantial number of press service clippings from Illinois papers as well as stories in Illinois papers based directly on the news release as received by the paper.

A number of special stories have been developed out of the postgraduate conferences, particularly at Jacksonville and Decatur, and, in both cases there was national use of the story.

The radio newscasters have also used many of the Society's releases, but there is no ready way to determine the extent of such use.

Again, at the suggestion of John W. Neal, executive secretary of the Committee on Medical Service and Public Relations, several stories were prepared and distributed throughout the state which had to do with the work of the Legislature and which he considered would be helpful.

Out of the work of the Educational Committee, several stories were prepared for the Illinois Congress of Parents and Teachers "Summer Round-Up."

Considerable time was spent in helping a staff writer for Medical Economics prepare articles about Medical problems in Illinois. This effort included reading and correction of proofs of the articles before publication, all of which was done in collaboration with Mr. Neal.

The newspapers, news services and radio stations have been extremely helpful and cooperative in their acceptance of the Society's material and we are greatly indebted to them.

Among other special services rendered by the public relations counsel was a weekend given to the ophthalmologists, collaborating and advising with them on some of their problems. A number of releases have also been prepared for the Women's Auxiliaries, particularly of Chicago, in an attempt to make this organization better known and increase its influence at the suggestion of Dr. Darwin B. Pond and Dr. Warren W. Furey.

In addition to the activities outlined so far, the bulk of the work done on behalf of the Society by the public relations counsel in the last year has concerned the following committees:

Committees on Rural Medical Service. At the direction of Dr. Harlan English, chairman, a brochure, "Doctors and Horses," was prepared and printed, outlining the views of the committee on the needs and methods required to improve rural medical care. The first printing of this pamphlet was ready in time for the National Farm Show in November, 1947, and the extent of interest in the subject is indicated by the fact that more than 4,000 copies were distributed there by the members of the Women's Auxiliaries who staffed the exhibit. Within the next three months, the remaining 6,000 of the original printing of 10,000 was quickly exhausted by an unprecedented demand and a new printing was immediately authorized by the Council. This will incorporate the details of the scholarship fund established by the Society and the Illinois Agricultural Association, as soon as they have been worked out by the joint committee.

When the committee announced its scholarship plan, news releases were worked out in collaboration with the Illinois Agricultural Association and distributed to the complete mailing list. At the same time it was discovered that the A. M. A. handbook for delegates and

other publications of the A. M. A. intended for wide distribution did not contain the plan; special efforts were successful in getting a full description incorporated into all the publications.

Another evidence of the interest in the subject is the fact that it has been possible to arrange the publication of two stories on rural medical education by the feature service of the Associated Press, both of which were used in great detail throughout the country. Finally, the Associated Press feature service assigned a reporter-photographer to prepare a page of pictures and explanatory news material on the activities and compensations of the rural medical practitioner. This was arranged to center around Dr. Lee T. Hoyt of Roseville by Dr. Harold Camp, secretary.

Committee on Tuberculosis Control. Tuberculosis has continued to be a major issue and the application of the influence of organized medicine has produced substantial results in Illinois. In Chicago, a complete plan for the rehabilitation of the Municipal Tuberculosis Sanitarium was worked out and put into effect. This included the appointment of a new board of directors who have cleaned up the hospital and revitalized the staff and services.

In Chicago outside Cook County, a new tuberculosis district was established by the petition-and-referendum method fixed by law and the recommendations of the Chicago Medical Society were accepted by the County Judge in the appointment of a board of directors, which is now preparing a tuberculosis control plan for an area with a population of some 750,000 people who had previously had almost no tuberculosis protection.

At the same time, officers of the Tuberculosis Institute of Chicago and Cook County, at the suggestion of the Tuberculosis Control Committee of the Chicago Medical Society, have undertaken to enter upon an elaborate campaign of public education on tuberculosis and have otherwise expanded and improved their activities.

These achievements have been made possible under the leadership of organized medicine by the recruitment of a committee for the eradication of tuberculosis which has brought into the fight all the elements in the community which are interested in the subject. The accomplishments with respect to tuberculosis and rural health especially illustrate the importance of the principles of aggressive assumption of leadership in health matters by the medical profession, which are discussed below.

The Illinois Medical Journal. Aside from the enhancement of the fame of the Journal by use of frequent stories based on its articles, the public relations counsel has sat in on numerous meetings of the Editorial Board and the Journal Committee, contributing wherever possible to their work, and helping in the preparation of material for publication.

The Committee on Prepayment Plans for Medical and Surgical Care. The need for widespread promotion of the idea of voluntary prepayment insurance has made this subject one of deepest importance in the public relations program. The counsel has attended practically all the meetings of this committee to familiarize himself with its work and thus to be a position to contribute as much as possibile to the expansion of this service. As noted above, two new versions of the pamphlet describing the plan have been prepared under the supervision of the chairman, Dr. Percy E. Hopkins, and the general counsel, Mr. John W. Neal. These have been printed and are being given the widest possible distribution.

Further elaborate efforts for the promotion of this program are now in preparation, since it is one of the most powerful instruments for developing public sentiment on behalf of the Society.

Educational Committee. For the Educational Committee the public relations counsel, who aided in the preparation of the exhibit which proved so popular at the last annual meeting, has collaborated in giving it an alternative form for use with lay audiences and also prepared an accompanying leaflet bearing the same title as the exhibit. "The Doctor and His Society." This exhibit is again on display at the annual meeting in an elaborated form developed by Mrs. Frances Zimmer and the public relations counsel at the direction of the Council. The editing of "Health Talk" has also occupied considerable time.

At the suggestion of Miss Ann Fox, secretary of the Educational Committee, the public relations effort was extended to include a series of meetings held by public health nurses to help them plan their public health nursing week for 1948 and also meetings at which plans for perfecting the summer round-up of the parent-teacher organization were discussed. These were in addition to the meetings of the Educational Committee itself.

A principle contribution to the work of the Educational Committee had to do with combatting the anti-vivisectionist movement. It was that a series of brief statements of arguments against this movement be prepared and mimeographed or printed and that each speaker placed by the Educational Committee be furnished a copy along with the suggestion that he incorporate some reference to the importance of animal research in his speech. This was adopted, the material was prepared by the public relations counsel, and is now being distributed by the Educational Committee.

More recently, a similar plan was proposed and is being carried out with respect to tuberculosis.

Recommendations

On the basis of two years' experience with a full scale public relations effort, the following discussion and recommendations are placed before the House of Delegates for consideration:

The public relations effort should be extended to counties and at the same time, through the service offered by the Society, coordinated throughout Illinois.

Organized medicine should aggressively and continually assume leadership in all matters pertaining to health. That, in one approach to the subject, might be taken as summarizing the whole public relations program of organized medicine. Medical men, for various obvious reasons, are usually too shy about appearing in the limelight. The result is that, though they have in fact been the moving force behind all

health advances, the public does not know it and thinks instead that medicine is socially remiss. Thus it is relatively easy to persuade unthinking persons that the government must take over. It becomes therefore the function of the public relations machinery on the one hand to persuade organized medicine to step into the forefront in all health problems and on the other to make the facts of medical achievement known to the public. If the public once appreciates those facts and makes them part of its thinking, its opinions will no longer be at the beck and call of the socializers.

The simplest definition of the public relations function yet formulated is this: "Do good; be good; tell the world about it." It might well be adopted by this Society.

It means that the activities of the organization must be planned and executed for the benefit of all the community and that the community must be kept thoroughly well informed of the facts. All three principles are of equal importance. Public opinion must be taken into account in all actions and the public benefit made an important factor in all decisions; at the same time, if the organization's efforts for the public benefit are to be fully appreciated, the public must know the facts.

The agency through which organized medicine can most effectively assume health leadership and plan, execute and publicize sound health programs is the county medical society. Its officers and members are most familiar with the multiple needs and problems of their own community. Their ideas and opinions carry weight. They have the power to recruit their own members into the effort and to influence their activities toward coordination to the statewide effort.

How shall the county medical society proceed? Obviously, the solution of the health problems of any community requires the efforts of more than organized medicine. Public officials and agencies, civic groups, organized labor, voluntary health and social agencies, newspapers and radio stations, school systems and their teachers and parents, women's clubs, even political and purely social groups, are some of the agencies which can bring influence to bear for the improvement of the health facilities of any community, if they know its needs. It is for the physicians of the community to tell them that.

Thus the first step could well be the organization of a health council, as recommended by the American Medical Association. The physicians should form such a group and play an active part in it. Once such a unit is formed, clearly it must never be allowed to deteriorate or to fall under the control of unsympathetic elements lest its values be lost, and, unless there is a determination to see it through, it should not be attempted.

The next step should be a survey of the community to determine its health needs, whether it is a new hospital, a new water supply, a modern milk ordinance, adequate health education in the schools, better contagious disease control or any of the many elements that make up modern health services.

The third step is to plan how to obtain whatever is needed. It is here that the health council, bringing all influences to bear on a subject on which all can agree, can play its most important role. It can be an agency of public education, of political pressure; it can support ordinances, bond issues, scholarships; it can organize meetings and referenda; it can recruit workers; in a word, it can do anything that will contribute to the achievement of its program, having to do solely with health under the sponsorship and guidance of the medical profession. At the same time the health council of any given community could, if it chooses, go beyond local issues and play a part in the promotion of such statewide activities as the improvement of rural medical care, the promotion of voluntary prepayment medical care insurance, hospital care insurance, support of state legislation such as that dealing with tuberculosis control, the regulation of cults and other problems of interest to health protection.

James H. Hutton, M.D., *Chairman,* Edwin S. Hamilton, M. D., Everett P. Coleman, M. D., *Committee on Medical Service and Public Relations.*

LEGISLATIVE REPORT

Among the increasingly numerous activities carried on by this committee, legislative affairs continue to form an important phase of its work. While the Illinois General Assembly has not been in session since June 30, 1947, and will probably not again convene until January of 1949, numerous important problems of state health legislation are under study. These, and many others, will doubtless be presented to the next session of the legislature for consideration.

Of importance among the matters under investigation by the committee are: the development of a legislative program to assist in the fight against tuberculosis; the need, if any, for mandatory postgraduate education for those practicing the healing arts; an affirmative program against anti-vivisectionism, to replace the essentially negative approach to the problem which has too often prevailed in the past; the legislative aspects of effectively dealing with substandard medical teaching institutions; and the improvement of our school health laws.

On the National legislative scene, the past year has been a most significant one for medicine and for the health of the Nation. The advocates of socialized medicine, while still dangerous and hard at work, have been forced to surrender the initiative, and to adopt defensive tactics. Congress, as well as public opinion generally, seems less inclined in favor of compulsory sickness insurance than at any time in the past five years. The planners were dealt a telling blow in February of this year when the results of a study by the independent and much respected Brookings Institution were announced. The Brookings report indicated, in effect, that the adoption of national compulsory sickness insurance would be a tragic and costly blunder.

Several other health bills of fundamental importance are pending in Congress. These have not attracted the attention which they would normally receive, due to Congressional preoccupation with the international

situation with its many legislative ramifications, and with tax reduction, presidential election, etc. While extensive hearings have been held on many of these health bills, no definite action has been taken, nor is any at this session likely. Among these proposals are the creation of a Department of Health of equal rank with the other Federal Departments, Federal aid in the school health field, and Federal aid to public health, education and research.

The close and effective cooperation in legislative affairs of numerous Society officers, councillors and other committees is gratefully acknowledged.

Respectfully submitted,
John W. Neal,
Executive Secretary.

REPORT OF THE MEDICO-LEGAL COMMITTEE

The Medico-Legal Committee continues its activities as an advisory and a liaison group. The usual number of calls for advice and assistance have come to the various members the past year.

While it is possible by examining the dockets of our various courts of law, to learn the exact number of suits for mal-practice in the State, we have not felt this an essential part of our duties. This information for statistical purposes might be useful. Our Committee has knowledge and has been called upon for help in about twenty cases, the major part of these being in Chicago. Many prospective witnesses have been interviewed, and court attendance has been deemed advisable in only one case.

As in former years fractures head the list of complaints, with burns a close second. Several of our members have been threatened or sued who do not have medico-legal protection, and since there seems to be good reason to believe that an increasing number of mal-practice suits will be instituted the next few months, we would again urge every one of our members to again examine his insurance folio.

Respectfully submitted, Oscar Hawkinson, M.D., *Chairman,* A. L. Nickerson, M.D., P. R. Blodgett, M.D., F. E. Bihss, M.D., Darwin B. Pond, M.D., Ralph McReynolds, M.D., *Medico-Legal Committee.*

DR. OSCAR HAWKINSON: In addition to what you have in your Handbook, I would like to urge all the members of the House of Delegates to ask your constituents to see about their medico-legal defense. It is very important. There is a tendency at this time all over the country to bring about malpractice suits. As you know, many of these are for the purpose of collecting easy money, which, of course, is a species of blackmail.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

To the Members of The House of Delegates:

Last year this committee presented a brief summary to the House of Delegates of the availability of hospital beds throughout the United States. Since this report was made, there has been some new construction but the shortage of hospital beds remains very acute. The cost of construction is so high that hospitals are very loath to proceed with their building programs. In order to erect a high grade private pavilion, the cost of construction amounts to about $20,000 per bed, so that it would cost approximately $10,000,000 just to erect a 500 bed hospital. An addition of only 50 beds costs approximately $1,000,000. It is doubtful that construction costs will become much lower in the next few years, and it would probably be desirable for all hospitals who can see their way clear to do so to make needed expansions at the present time. Great care must be taken, of course, not to overexpand.

Physicians, themselves, can improve the hospital situation somewhat by not admitting to the hospital any patients who can be thoroughly studied in their offices. Many patients with medical problems can be thoroughly studied and adequately treated without hospitalization. Keeping patients of this type out of the hospital not only makes more hospital beds available for acutely ill patients, but also reduces the cost to the patient of being ill.

The Cost of Hospitalization

Hospitals have been faced with constantly rising costs. The cost per patient per day varies in different parts of the country and varies from hospital to hospital in the same location. In Chicago it varies between $16 and $18 per day. In Cleveland and Detroit it varies between $18 and $20 per day.

It is hoped that costs will not rise much further, but they may rise some because all hospitals are faced with the necessity of paying higher wages for certain types of service, as for example, nursing care. The cost of hospital insurance has risen correspondingly and will continue to rise as long as hospital costs keep rising. The cost of hospital insurance has also been increased by the admission of patients who do not need to go to the hospital.

The Role of The Hospital in Medical Education

Leading teaching hospitals have no difficulty in securing interns and residents, but some of the non-teaching hospitals have a great deal of difficulty. The problem is complicated by the fact that residencies in many non-teaching hospitals are either not approved or approved for only one year of training. Hospitals should make every effort to make their teaching program for interns and residents as attractive as possible, and raise the standards sufficiently high so that approval for longer periods of residency training may be secured. In some instances it might be possible for the hospitals to work out cooperative arrangements with the medical schools in the training of the interns and residents. This would mean that the standards of the teaching program would have to be raised so that they would be acceptable to the schools and it would also broaden the sphere of influence of the schools in medical education. One university in the western part of the country has worked out a training

program for residents in a great many hospitals all over the state and in surrounding states. All residents are required to take a course in basic sciences which is given by the university as part of the residency training. It would be desirable if a similar program could be worked out in the State of Illinois.

The General Practitioner

The problem of the general practitioner remains a serious one, although certain steps have been taken to solve the problem. The American Medical Association has established a section on general practice and an Academy of General Practice has been formed. One of the requirements for membership is evidence of attendance at postgraduate courses for a total of 150 hours every two years.

A few hospitals have set up departments of general practice with representation on the Executive Committee of the Staff. Such a development would appear to be highly desirable for most hospitals. A great deal of consideration needs to be given to the type of training which general practitioners need. They may be trained with either special types of internships and residencies or with the proper combination of those which now exist. The training of men for general practice should be set up in such a way that those who wish to specialize later will be given credit for their work in general practice towards certification by one of the specialty boards.

The term "general physician" has been suggested by Dr. Bierring as a better designation than "general practitioner." Men doing general practice constitute the great majority of physicians and it is our responsibility, as a profession, to do everything in our power to elevate the general practitioner to the status in the community which he deserves.

Group Practice

In many instances physicians interested in various fields of medicine have formed a group on the theory that they could render better medical care to the community than in the individual practice of medicine. The groups which have already been formed appear, in most instances, to be rendering a high type of medical service. The development of groups will probably continue to increase, but nothing must be done to disturb the relationship between the patient and the physician. A great many problems which patients develop are emotional in nature and fall in the realm of psychosomatic medicine. They can often be handled best by the doctor who has an intimate knowledge of the patient and his background over a period of many years.

The Nursing Problem

The nursing shortage continues to be acute. In spite of the very serious nursing shortage in some hospitals, other hospitals have an adequate supply of good nurses and seem to have no trouble in filling their quotas in the nursing schools. Hospitals which have no shortage of nurses appear to be those which make the nursing profession more attractive by paying higher wages, providing nurses with adequate living accommodations, and making the educational opportunities in the nursing schools attractive.

It would appear to the Committee that the most important cause of the nursing shortage is economic. Nurses in general have been underpaid and they have not had an opportunity to advance themselves financially in their profession in a manner which corresponds to the opportunities for women in business. Nurses who render valuable service to hospitals over a period of many years should receive definite advances in remuneration each year, and should have some retirement arrangement so that they will be adequately taken care of as they grow older.

Postgraduate Medical Education

One of the most important problems in medical education is the provision of adequate opportunities for the continuing of education of physicians. Medical knowledge is increasing so rapidly that physicians must constantly keep up to date. Several years ago the Illinois State Medical Society established a Committee on Postgraduate Medical Education and began conducting postgraduate days in various parts of the state. This activity might well be expanded. A few years ago the Chicago Medical Society started an Annual Clinical Conference, which represents a four-day intensive postgraduate course for the general practitioner. Leading teachers from all over the United States participate in this conference and doctors attend it from all over the country. In 1947 the Chicago Medical Society established a Committee on Postgraduate Medical Education to provide short intensive postgraduate courses for physicians. The first two courses were given in the fall of 1947 and a course of one week's duration in cardiovascular diseases was attended by 135 physicians from various parts of the United States and Canada. A course in gastroenterology given the following week was attended by 103 physicians who also came from various parts of the United States and Canada. The faculty included leading teachers from all over the country. Two more courses will be given this fall. A course in hematology and neurology will be given during the week beginning September 13, and a course in cardiovascular and respiratory diseases during the week beginning September 20. These courses are open to all physicians in good standing in their local medical societies. A registration fee of $50 for each course is charged to cover costs. The Chicago Medical Society believes that the development of postgraduate medical education represents one more step in the development of Chicago medicine. These courses supplement the activities of the medical schools. The medical schools are more interested in longer periods of training which are provided by internships, fellowships, and residencies, and are very happy to cooperate with the Chicago Medical Society in the development of these short intensive courses.

The Medical School Problem

There are four approved medical schools in Chicago. The University of Chicago, the University of Illinois, Northwestern University, and Loyola University all have approved medical schools, and all have plans for the expansion of their educational opportunities in

medicine. There still remains one unapproved medical school in Chicago, and, as a matter of fact, it is the only unapproved school in the United States. We refer to the Chicago Medical School. Last year the problem of the Chicago Medical School was assigned to this committee, and in 1947 we made a report of our investigation to the Council of the Illinois State Medical Society and to the House of Delegates. The opinion of the committee, of the Council, and of the House of Delegates is that every effort should be made to assist this school in its problem of securing enough clinical facilities to warrant approval. The teaching in the first two years is now apparently of sufficiently high caliber to warrant approval. The problem lies in the lack of facilities for clinical teaching in the last two years. The following communication has been received from Dr. Sheinin, Dean of the Chicago Medical School.

The Chicago Medical School

Dr. Willard O. Thompson, Chairman,
Committee on Medical Education and Hospitals,
The Illinois State Medical Society,
700 North Michigan Avenue,
Chicago, Illinois.

Dear Dr. Thompson:

In reply to your inquiry of recent date, I am pleased to advise you of the following improvements that have taken place at our School since the survey of May, 1948:

A. Affiliation with Mount Sinai Hospital.
 1. Complete transfer of our dispensary from the medical school building to the Mount Sinai Hospital and reorganization of their dispensary into a teaching unit. The number of available patients for teaching in the dispensary has been doubled.
 2. Institution of clerkships in Medicine, Surgery, Obstetrics and Dispensary at the Mount Sinai Hospital.
 3. Appointment of the following personnel on a fulltime basis: Medicine (2), Surgery (2), Obstetrics (1), Dispensary (1), student-clerk secretary (1), clinical technician (1). In addition to a halftime psychiatrist, our former dispensary supervisor, assistant, secretary, record librarian, and additional admission social worker have been added to the Mount Sinai Dispensary staff.

B. Because of the transfer of the dispensary from the School, the vacant quarters have been converted into research laboratories, office laboratories, and offices, which have been added to the preclinical departments. As a result of the foregoing, the following additions have been made:
 1. Department of Anatomy—anatomy library, research laboratories, and office laboratories; greatly improved microscopic technique quarters; X-ray and fluoroscopy room (for Anatomy, Physiology, and research).
 2. Department of Chemistry—office and research laboratories and electrophoresis department.
 3. Department of Physiology—research and office laboratories.
 4. Department of Pathology—research and office laboratories.
 5. Department of Microbiology—research and office laboratories.
 6. Library—addition of one stack room.
 7. Four additional animal rooms.

C. Additional Cook County Hospital services were secured: Medicine (2), General Surgery (1 effective July 1, 1948), Genito-Urinary Surgery (1), Obstetrics (1), Tuberculosis (1), Thoracic Surgery (1).

D. Preclinical personnel.
 Preclinical personnel was added as follows: Department of Anatomy (4), Department of Physiology (1), Department of Chemistry (2), Department of Pathology (3, one as of July 1, 1948), Microbiology (3); considerable increase in the technical staff.

E. Clinical personnel.
 A considerable number of voluntary clinical personnel have joined our staff, of whom an impressive number are certified by their respective Boards and have had teaching experience in other schools.

I wish to state that because of the complete cooperative and scientific zeal of the Board of Trustees and the staff of the Mount Sinai Hospital, the following holds true. All services, as well as private cases in Medicine, Surgery, and Obstetrics, at the Mount Sinai Hospital are being freely utilized for the teaching of our students, and that teaching is done under the supervision and direction of full-time men who are certified in their respective fields. The full-time staff of the hospital, which is appointed by the School, is not allowed to participate in the practice of Medicine or consultation, and are required to spend their entire time in teaching and investigative work.

In reference to your direct question dealing with the School's approval, may I suggest that the answer can only come from the authoritative accrediting parties.

Assuring you of our sincere appreciation of your interest in our progress, I am

Cordially yours,
Signed by John J. Sheinin, Dean.

JJS:LL
CC: Prof. A. C. Ivy.

It would appear from this communication that the school has made definite progress during the past year. The Committee tried to persuade one of the other hospitals to affiliate with the Chicago Medical School, but this hospital already had plans for the development of a postgraduate school of its own and did not feel justified in proceeding with an affiliation at the present time. The Committee hopes that some other hospital or hospitals will see their way clear to affiliate with the Chicago Medical School in a teaching program in order that the school may be approved. Such an affiliation would be beneficial not only to the school, but also to the hospitals involved because it would improve the caliber of the staff and of the teaching program for interns and residents. It is the opinion of the Committee that hospitals making such an affiliation would have nothing to lose and much to

gain. Once the Chicago Medical School is approved, it will have much less difficulty in securing funds for expansion of its physical plant and improvement of its teaching program.

As members of the Illinois State Medical Society, we are all interested in doing everything we can to improve the quality of medical education in the state. Chicago, by virtue of its strategic geographical location and as a result of the constant improvement in its educational facilities, has already become a leading medical center and we all hope to make it the medical center of the world.

Respectfully submitted, W. O. Thompson, M.D., *Chairman,* A. C. Ivy, M.D., H. O. Munson, M.D., *Committee on Medical Education and Hospitals.*

REPORT OF THE COMMITTEE ON ARCHIVES

To the Members of The House of Delegates:

During the past year the Official Photographer has secured many new pictures of Illinois Physicians for the permanent file. A questionnaire has been prepared and is sent with each set of proofs so that essential data about each doctor is available at the time the approved photograph is filed in the Illinois State Historical Library.

Drs. D. D. Monroe and E. H. Weld have attended several meetings held jointly by the Committee on Medical History and the Committee on Archives held throughout the state. The purpose of these joint meetings is to plan another volume carrying forward the "History of the Illinois State Medical Society, and the Progress of Medicine in Illinois."

Respectfully submitted, D. D. Monroe, M.D., *Chairman,* E. H. Weld, M.D., C. Ellsworth Black, M.D., *Secretary, Committee on Archives.*

REPORT OF COMMITTEE ON MEDICAL TESTIMONY

To the Members of The House of Delegates:

The Committee on Medical Testimony whose activities are patterned after the so-called Minnesota Plan, was authorized by the House of Delegates at the May, 1947, meeting. Since no machinery had been set up for choosing this Committee, the president of the society was empowered by the Council to make these appointments.

A Committee of this type made up of four members has been functioning in Cook County for two years. In this number there being one surgeon, one internist, one roentgenologist, one urologist. This group was included in the Committee appointed by the state president.

The function of this Committee is to review complaints against any of our members who wilfully or carelessly by their testimony in our courts defeat the ends of justice. Complaints have been received about the testimony of eleven Chicago doctors, four of whom are not members of the society. Those who are members were all called before the Committee, their testimony discussed and discrepancies reviewed; all in a friendly, reasonable manner, but with a definite understanding that it is the purpose of the Committee along with the active cooperation of the Bar Association to discourage all testimony which is confusing, contradictory or wilfully misleading.

One case has been reported from southern Illinois, in which the court after due investigation of a case in which there was marked discrepancy in the testimony, cited the recently adopted Minnesota Plan, which has the approval of the Illinois Association of Judges as well as the Bar Association; then secured a retraction and an apology from one of the medical witnesses.

It is our hope that the work of this Committee may be widely publicized thereby lessening cause for complaints, and the not too pleasant duties of the Committee.

Respectfully submitted, Oscar Hawkinson, M.D., *Chairman,* Walter L. Palmer, M.D., Warren W. Furey, M.D., Harry A. Oberhelman, M.D., Everett P. Coleman, M. D., Arthur F. Goodyear, M. D., E. H. Weld, M.D., W. J. Gillesby, M. D., *Committee on Medical Testimony.*

REPORT OF THE COMMITTEE ON MEDICAL BENEVOLENCE

To the Members of The House of Delegates:

The Benevolence Committee established by the House of Delegates about ten years ago, has rendered splendid service to many of our colleagues and their dependents who were in dire need. The past few months there has been an increasing number of requests for aid, and at this time fifteen are receiving monthly checks ranging from $20.00 to $50.00. At present value, this is not a large sum but does prove a stop gap, and in some instances is life saving.

This Benevolence Fund from the earliest days was appropriated from the general treasury of the Society. The Woman's Auxiliary contributed liberally from their meager reserve; other means of securing these funds have been discussed, such as special assessments, etc., and about a year ago the Council approved a plan to secure, by popular subscription a sum large enough, which when properly invested, would produce sufficient income for our needs.

This campaign is now in progress with very indifferent success. About ten thousand dollars have been collected, which is about one dollar per member. If every man in the Society were willing to carry his share of the load, our objective could be easily attained, and a very worth-while project carried out successfully.

Respectfully submitted, Oscar Hawkinson, M.D., *Chairman,* Lee O. Frech, M.D., Harold M. Camp, M. D., Secretary, *Committee on Medical Benevolence.*

DR. OSCAR HAWKINSON: A year ago we were very confident that we would raise a large sum by

popular subscription that we would have $100,000 or $200,000, a sufficient sum which if placed at interest would enable us to take care of those in distress. At this time we have collected $12,000 or $13,000 by popular subscription, about one dollar per member. That is not very much and the Committee is quite discouraged. I understand there is a resolution coming up for an increase in dues and to have this increase in dues in the future allocated to the Benevolence Fund. A year ago I would have been opposed to that, but we have had no results fom the subscription and I am in favor of asking for an increase in dues to be allocated to this Fund.

REPORTS OF COUNCIL COMMITTEES

REPORT OF THE EDUCATIONAL COMMITTEE

To The Members of The House of Delegates:

The following report is submitted for activities of the Educational Committee during the year ended April 1, 1948. Physical changes included the cleaning and redecoration of the Office and the addition of some new equipment. One additional staff member, Miss Josephine Linder, was employed to meet the increasing demands for service to the general office. The Chicago staff includes the Secretary of the Educational Committee, Miss Ann Fox, Mrs. Kathryn Simmons, Miss Linder and Mr. Patrick Mahoney. Telephone equipment was extended from one to three lines, a change which necessitated, unfortunately, the losing of a number that had been identified with the society for many years. In March another change occurred; the present number is Financial 0443.

The Chicago Office has been completely reorganized not only in handling and expediting the work, but in systematizing routines that have resulted in marked efficiency. In presenting this report, the Educational Committee notes that it expresses the first full year under the reorganization and presents but a superficial account of the time expended by the Committee, the Secretary and members of the staff in the discharge of their responsibilities.

During the year the Committee met five times: April 19, 1947; May 24, 1947; October 4, 1947; November 18, 1947; and March 6, 1948. At each meeting the Secretary submitted a detailed report of her activities extraneous to the close contact maintained regularly with the respective members of the Committee.

SPEAKERS' BUREAU—

For the year ended April 1, 1948, 118 speakers were scheduled before the following organizations: Women's Auxiliaries, Parent Teacher Associations, Women's Clubs, Career Clubs, Business and Professional Groups, Young Mothers' Clubs, Y.W.C.A.'s and Y.M.C.A.'s, Rotary, Lions, and Kiwanis Groups, Groups of School Children, Bohemian Woman's Civic Club, American Veterans' Committee, Burnham School of Cosmetic Hygiene, Church Groups, Beverly Hills Non-Partisan Organization, Medical Society of Milwaukee County, County Tuberculosis Associations, Architects Association of Illinois, Optical Wholesalers National Association, P. E. O. Groups, Hillel Alumni Association, Dow Optical Company, Young Married Couples Sunday Evening Club, Chicago Woman's Aid, American Lady Corset Company, Civic Federation in Peoria, Norwegian Lutheran Children's Home. Obtained film from the National Foundation for Infantile Paralysis for physician in New Haven, Illinois.

This total does not include the nine speakers scheduled before similar groups through April and May of this year, a period extending beyond the close of the report. Nor does it include a special request for a general practitioner to participate in a Career Conference of North Central College, the first of its kind, scheduled for April 21-23.

In addition, films were scheduled for various Parent-Teacher Associations, the one entitled "When Bobby Goes to School" produced through Mead Johnson and Company, Evansville, Indiana, being the most popular.

The revision of the panel of speakers for non-medical organizations was completed in July, following a general circulation to the existing panel and a special letter to county medical society secretaries requesting the names of doctors who would be available for talks to the public.

The original plan to incorporate the names of the speakers in a booklet was abandoned because of the possibility that the booklet might be put to indiscriminate use.

At the beginning of the revision, 150 names were in the file. On March 16, 1948, eighty-four new names had been added to the panel, making a total of 234 physicians throughout the state who were available for educational talks before the public.

This total is significant in that many of the physicians who appear in this group are also listed in the Scientific Panel. In addition, many of the physicians in the Scientific Panel and not classified in the lay panel may be called on for a specific topic.

In every instance when a certain physician was requested, the invitation was issued, because the Committee believe that the individual physician cooperating in the panel has a right to know of the specific request.

The topics covered include: Tomorrow's Child, Health in the School and Home, Leisure and the Child, Superstitions and Fallacies About Health Program, An Ideal Health Program for Children, Tempers and Tantrums, Voluntary Health Insurance, The Responsibility of Youth in the National Health, Problem Parents, Health Hints, Health and Personality, Keeping Your Body Fit, Hitting the High Spots in Health, Surgical Treatment of Pulmonary Tuberculosis, Hospitals and Rural Health Centers, Tuberculosis—A Problem in Illinois, Obesity, Glands and Personality, Socialized Medicine—What It Would Mean to the Optical Industry, Walking Through Life, "The Wonderful One Horse Shay," Why We Are Growing Older, At the Cross Roads, The Health Challenge in Our Schools, Cancer and You, What We Are Doing About Cancer, Food and Drug Watchdogs, Care of the Skin and Skin Diseases Commonly Seen, Tuberculosis,

Learning to be a Good Citizen by Observing Good Health Habits, Recent Advances in Medicine, Preventive Medicine, Mental Hygiene as it Affects the Adolescent, Various Aspects of Nutrition, Child Behavior Problems, Leukemia and Related Blood Diseases, Guiding the Family to Better Health and Safety, Care of the Growing Child, Cosmetics—Their Use and Abuse, Cancer and the Menopause, The Venereal Disease Problem and the Community, Why We Have Progress in Medicine, Feminine Hygiene, Health Insurance as it Affects the Individual, Skin—Hair and Cosmetics, Cancer, What Is Heart Disease, Instructions in Matters of Sex and Mental Health, What Parents Should Know About the Psychology of Children, War and Disease, Child Guidance and Behavior Problems, Public Health, Sex Hygiene, Communicable Diseases, Today's Critical Nursing Shortage, The Menopause, Physical, Mental and Emotional Needs of Children, Health of the Pre-School Child, The Expanding Field of Research, Advances in Cancer—Research Development and Treatment, Prepayment Medical Care Plan, Anatomical Structure of the Feminine Body, Growing Old Gracefully, Anti-Vivisection, Acute Conditions of the Abodmen, Health of the Growing Child, The Parent's Responsibility to Society, Ten Point Prepayment Medical Care Plan, Blood Pressure, Facing the Forties, Seven Cycles of Life, Legislation, Keeping Children Healthy, Public Health and Child Hygiene.

HEALTH TALK—

On April 1, 1947, the weekly mailing list of HEALTH TALK was 402; on March 15, 1948, it was 543. This total includes the weekly press of Illinois, some individual physicians, nurses and teachers. For the corresponding period, the two selected copies sent each month to individuals totaled 4,282 and 4,346, respectively. In addition on March 16, 1948, 350 copies of each issue were going to six persons representing schools and farm bureaus for their personal distribution.

At the time this report was prepared, 151 schools of the Order of St. Francis had not yet been added to the mailing list, although the request was received March 15, as had not the names of 12 individuals. It is estimated that on April 15, the monthly mailing list to individuals, schools and libraries would total 4,509.

With the February 15 issue the revision of the mailing list was begun. It is significant that for every name removed, two names were added to the list.

In the process of revision, the following comments were received on the return cards: "I think it's fine," "HEALTH TALK is very instructive and much appreciated," "I enjoy every issue," "Helps much in my classes," "Yes, please, I like them and use a number of them. Very glad to get the one today—Health, A Year Round Program." The head of the department of Health and Physical Education stated: "Kindly keep sending these. We have an extensive health course and use these talks." "Sure Do!" "Very definitely." "I enjoy it very much." "Indeed." "You bet!" "I give Health Talks at home bureaus." "Thank you for the leaflets—Keep up the good work." "My classes find them worthwhile too," "I like these articles a lot." "By all means. Your articles are wonderful!" "Use it a great deal." "I use it in health classes at the high school where I teach." "I find it very valuable." (Lane Technical High School). "I like Health Talk very much." (Registered Nurse of the American Public Health Association). "It is received extremely well." "We use it on bulletin boards" (Y.M.C.A.). "Could I have two copies each time? Would like to pin one on our club bulletin board and keep one for myself." "Very enlightening." "Very helpful and instructive." (Representative, 23rd Senatorial District, Illinois General Assembly).

During the year, the following excerpts from letters reflected interest in HEALTH TALK: "These are very interesting to all of us concerned with special education." (Director, Special Education, Evanston Public Schools.) "Just a note to let you know how well we think of your recent innovation entitled HEALTH TALK. We have read the issues with a great deal of interest and have found them uniformly of high quality." (Illinois Society for Mental Hygiene.) A Harvard University Professor requested his name on the mailing list and the Ohio State Medical Association asked for a complete file for consideration by their committee for extension of their activities.

DISTRIBUTION

One hundred copies were distributed at a regional conference of the Council on Medical Service, AMA, at a meeting in New Orleans, October 23, 1947.

Thirty-one hundred copies were enclosed in the News Letter of the same Council in October.

Seventeen hundred copies of one issue "Care for Tiny Tots," were requested for distribution in the mailing list of the Illinois Society for Mental Hygiene. In addition certain issues were requested by PTA health chairmen, nurses and teachers in amounts ranging from 25 to 75. Other state medical societies have expressed interest in the development and distribution of HEALTH TALK and many have requested permission to reprint with the credit line to the Educational Committee. Some journals of state medical societies have published certain issues. Hygeia used an excerpt from one.

It is interesting that some small club groups used several issues for discussion at meetings.

Evidence that the newspapers like the special two page story in neat news release style, double spaced with reasonable margins is reflected in the use of 6 and 8 point heads accompanying the column. The appearance of HEALTH TALK in the metropolitan papers of Chicago, the Tribune, the Sun-Times, the Herald-Examiner and the News, is further proof of its popularity.

The rapidly increasing mailing list presented an economic problem. To meet this, the two selected copies for monthly mailing are printed in two columns, one page being devoted to each issue. This change was made in January and results in a potential annual saving of approximately 120,000 sheets of paper. This will be absorbed, however, as the mailing list increases. The two color printing job was abandoned to affect a further saving, and the 6x9 Manila envelope was sup-

planted with the number 10. All these changes yielded a net saving of more than $13 for each 5,000.

HEALTH TALK is prepared on a three month advance schedule and Monday of each week is the deadline for the weekly mailing while the fifteenth of the month is the deadline for the monthly lay list.

HEALTH TALK made its informal appearance in December, 1947. Its formal appearance was dated February 7 under the title "Where Can the Tuberculous Patient Go?" Since that time the following titles have been covered: The Care of the Old, That Tired Feeling, Pneumonia, Community Cooperation in Tuberculosis, Laughter and Health, Blood and Its Pressure, Your Child's Health, Cancer, The Economics of Tuberculosis, Your Doctor's Health, The Annual Checkup, The Endocrine Glands, What You Can Do About Tuberculosis, Know Your Doctor, Protection Against Smallpox, What Research Does for You, Take Your Sun Carefully, Painful Feet, Understanding the Alcoholic, Vacations, Do You Swim for Health, Do You Suffer from Hayfever, Do you Want a Doctor, Guard Against Ringworm, What Do You Gain from Worry, Prescriptions Are Not Mysterious, Poliomyelitis—The Crippling Disease, The Specialties and General Practice, Tips on Posture, Rheumatic Fever, Going to School, Eating for Health, Help for the Spastic Child, Leukemia, A Fatal Disease, Care for Tiny Tots, Epilepsy, Tuberculosis, the Killer, Self-Medication is Dangerous, Diphtheria—the Strangling Disease, The Common Cold, Do You Have Diabetes, The Chronically Ill, Drive for Safety, Keep Your Holidays Happy, Help Prevent Pneumonia, Your Skin, Why Breakfast is Important, Low Blood Pressure, Understanding the Eye, Health—A Year Round Program, What Is Heart Disease, Prevent Whooping Cough, Keeping Trim, Can You See, Health Police—The Public Health Nurse, Window of Your Ears, Does Your Head Ache, Cancer Facts, So You're Expecting a Baby.

HEALTH TALK attempts to meet health campaign ideas as an educational medium. For example, when the tuberculosis program was being waged during the past year in the legislature, five issues were devoted, periodically, to the subject. Issues were devoted to animal experimentation and the need for research and, in addition, with the coperation of the Committee on Medcal Service and Public Relations, a series of suggestions was mimeographed and is included in a letter to every speaker before a lay organization, one or all of which may be incorporated in any talk on a medical topic. A similar project is now under way for tuberculosis.

EXHIBIT—

The idea for the "Doctor and His Medical Society" stemmed from the Educational Committee. The exhibit, worked out in conjunction with the Committee on Medical Service and the Secretary of the Illinois State Medical Society, outlines the activities of the Illinois State Medical Society, showing the formal organization structure with the physician as the fundamental unit; the county society as the second step; the state medical society as the third level and expressing the delegates to form the national level. In cooperation with the Committee on Medical Service and Public Relations, the exhibit has been shown at the following places:

1947

May 12-14—Annual Meeting, Illinois State Medical Society, Palmer House, Chicago.
August 9-17—State Fair, Springfield.
September 17—PTA Regional Conference, Hamilton Park, Chicago.
November 4—North Shore Branch, Chicago Medical Society, Edgewater Beach Hotel.
November 5—University of Illinois College of Medicine.
November 29-December 7—National Farm Show, Coliseum, Chicago.
December 9—Loyola University School of Medicine.

1948

January 12—North Suburban Branch, Chicago Medical Society, University Club, Evanston.
January 13—University of Chicago School of Medicine.
February 3—Northwestern University Medical School,
March 14—Secretaries' Conference, Peoria.

In addition it is scheduled for the Scientific Exhibit of the AMA Annual Meeting in Chicago in June, a PTA meeting in Springfield, April 8-10, and the Illinois Federation of Women's Clubs in Chicago in May.

In December a new panel was developed to depict the activities of many committees for showing before lay groups. So successful has been the exhibit that requests have come from physicians and other state medical societies for photographic reproductions. The successful staffing of the exhibit at the National Farm Show in Chicago is attributed solely to excellent liaison between the Women's Auxiliary to the Illinois State Medical Society.

PACKAGE LIBRARIES—

Since April 1, 1947, the following subjects have been covered: Fatigue, Soil Conservation, Cancer, Medical Ethics, Reducing, Streptomycin, Environment, Heart Disease, Sex Education, Prostate Gland, Goiter, Socialized Medicine, Premature Infant, Plastic Surgery, Rheumatic Fever, Alcoholism, Rh Factor, Rabies, Physical Therapy, Burns, Posture, Epilepsy, Leprosy, Smallpox, Undulant Fever, Whooping Cough, Foot Care, Sunlight and Health, Medical Advances in World War II, Tobacco and Alcohol, Mental Health of the Child, Exercise, Aspirin, Posture, Obesity and Underweight, Child Health, Asthma, What People Believe, Diabetes.

LIAISON—

Council on Social Agencies, Chicago Industrial Health Plan, Association of Women, American Federation of Farm Bureaus, Illinois Congress of Parents and Teachers, Illinois Federation of Women's Clubs, Cook County Department of Public Health, Bureau of Health Education, American Medical Association, Chicago Dental Society, Illinois Department of Public Health, Illinois State Nurses Association, and other agencies Department of Mental Hygiene.

On January 30, the secretary of the Educational Committee was chosen by representatives of the First District, Illinois State Nurses Association, and other agencies as general chairman of the 1948 observances

of Public Health Nursing Week, April 11-17, covering the areas of Cook, DuPage and Lake Counties. This honor given to the secretary also brought increased responsibilities but is considered a splendid avenue of cooperation between the Educational Committee and the allied groups in the area.

During the past year the Secretary has attended many meetings of local, regional and national importance. These included the Annual Session of the American Medical Association, the Conference of the Physician and the Physical Educator in Highland Park, the Conference on Rural Health, AMA, Secretaries' Conference of the Illinois State Medical Society in Peoria, the Illinois State Fair in Springfield, the special meeting to implement the President's Commission on Higher Education sponsored by the Chicago Woman's Aid, Women's Share in Public Service, Council on Social Agencies, state and regional meetings of the Illinois Congress of Parents and Teachers, the health session of the Illinois Federation of Women's Clubs, the North Suburban and North Shore Branches of the Chicago Medical Society, Federation of Medical Examining Boards, National Society for Crippled Children, Women's Auxiliary meetings, Industrial Editors' Association of Family Living.

In addition the services of the Secretary have extended to the Annual Dinner Committee, Committee on on Arrangements for the Annual Meeting, Section on Obstetrics, the Medical Economics Committee, the Committee on Maternal Welfare, the Committee on Medical History, the Committee on Rural Medical Service and the Veterans Service Committee, now to be known as the Committee for Military Affairs and Emergency Medical Service.

The Secretary is responsible for the news pages of the Illinois Medical Journal and the column entitled "For the Common Good" and the obituaries.

LITERATURE—

"The Doctor and His Medical Society," a pamphlet discussing activities of the Illinois State Medical Society and the society's exhibit, made its appearance in December. This four page leaflet has been widely distributed. "Doctors and Horses," a new brochure developed by the Committee on Rural Medical Service and the Committee on Medical Service and Public Relations was distributed by the Educational Committee

SERVICES—

Through the extended activities of the Committee, extra responsibilities have developed in the Chicago office. The staff has been responsible for the preparation and mailing of certain news releases to the press, to the Journal of the American Medical Association and the Bulletin of the Chicago Medical Society. With the appearance of the column the speakers were classified under the committee responsible for their appearance, a format which clearly delineates the functions of the committee. Mimeographing service has been provided for the nurses activities in promulgating the Public Health Nursing Week, the Chicago Dental Society, the Woman's Auxiliary. The minutes of a special committee meeting of the Chicago Ophthalmological Society were not only prepared by the Secretary but mimeographed and mailed to each member by the Chicago staff of the Illinois State Medical Society. Service was given to individual physicians in the way of typing letters and manuscripts.

The Committee in cooperation with the Cancer Control Committee has assisted the division of cancer control, Illinois State Department of Public Health, with some of its activities, particularly in the way of advice and counsel.

QUERIES CONCERNING SERVICES—

Dick Graham, Oklahoma State Medical Association; Tom Walsh, Medical Society of the State of New York; Dr. V. Friedrich and Mr. Frank Lais, Jr., Public Relations, Louisiana State Medical Society; Dr. Carroll Andrews, California Medical Association; Mr. Don Taylor, Public Relations, Iowa State Medical Society; Mrs. Edna Splittler, AMA; Mr. M. L. Meaders, Public Relations, South Carolina Medical Association.

CONCLUSION—

The Educational Committee presents this report to the House of Delegates as a testimonial that the work of the Committee is expanding. It acknowledges with appreciation the constant cooperation of the individual physicians participating in its Speakers' activities, the respective Committees of the Illinois State Medical Society, particularly the Committee on Medical Service and Public Relations, whose activities are so closely enmeshed with those of the Educational Committee, and the Office of the Secretary, Dr. Harold M. Camp, whose support has been unwavering in advancing the best interests of the Society.

To the Council of the Illinois State Medical Society, the Committee expresses its gratitude. The expanding efforts of the Committee can be attributed largely to the confidence shown by this executive group.

Respectfully submitted,

Charles P. Blair, M. D., *Chairman,* Warren W. Furey, M. D., *Vice Chairman,* Ford K. Hick, M. D., C. Paul White, M. D., Ann Fox, *Secretary.*

REPORT OF THE SCIENTIFIC SERVICE COMMITTEE

To The Members Of The House of Delegates:

It is my pleasure and privilege to present herewith the annual report of your Scientific Service Committee.

Assistance to the County Medical Societies of the Illinois State Medical Society is the principal function of the Scientific Service Committee. The Committee arranges programs for some county medical societies and furnishes releases and postcard notices of meetings to other county medical societies who prefer to invite their own speakers. This report attempts to outline the various services extended to county medical societies during the year ended April 1, 1948.

For years the Scientific Service Committee has been attempting to restrict the travel distance of speakers before county medical societies to not more than 50 miles. However, during the past year, requests for certain speakers from downstate counties required the traveling of 150 miles or more to fulfill many of the

programs. The acceptance of these invitations issued through the Scientific Service Committee by individual physicians is perhaps the most outstanding keynote of professional cooperation in the formal services of the Scientific Service Committee.

The following indicates the societies serviced and the number of programs arranged. In addition other services are indicated.

Societies	*Times*	*Newspaper Releases*	*Return Postcard Notices for dinner reservations*	*Postcard Notices*
Bureau	4	40	389	
DeWitt	1	50	53	
DuPage	3			
Effingham	1	4		65
Henry	4	120	376	
Kankakee	2			
LaSalle	7	235	703	
Lee	1	24	128	
Livingston	2			
Logan	5			
Macoupin	2			
Marion	1			
McDonough	2	40	152	
McLean	1			
Morgan	3			
Randolph	2	7	50	
St. Clair	1			
Saline	1			
Vermilion	8			
Whiteside	1	50	114	
Will-Grundy	15			
Winnebago	1			

These figures (or totals) will show that of the 92 county medical societies, only 22 requested the services of this Committee.

In addition, joint meetings were arranged as follows: Five County Medical Society covering Clark, Jasper, Richland, Lawrence and Crawford Counties 2, and Six County Medical Society including counties of Perry, Jackson, Randolph, Union, Franklin and Williamson, 1. Return postcard notices were sent for these groups for the number of times indicated and in addition, for meetings arranged by themselves as follows: Six County, 5. In addition to the notices sent for Lee and Whiteside Counties for their respective meetings, two joint meetings were handled with notices to the membership. Two speakers were obtained for different meetings for the Rockford Memorial Hospital School of Nursing, one of which had to be cancelled because of a change in personnel. Assistance was given on three occasions to the Iowa-Illinois Central District Medical Association in arranging programs.

For reasons of accurate record for a prescribed year, the schedule of speakers runs through the year ended April 1, 1948. Noteworthy is the advance schedule met by Will-Grundy, Logan and Vermillion Counties. These three counties early in the year set up their programs through May and June. The speakers have been scheduled but are not included in this report. McDonough County, a new group to ask for assistance this year, is another society that has set up an advance schedule. Beginning with a program February 27, their meetings have been arranged through November. Again these speakers have not been included in the totals for the year ended April 1.

On December 19, 1947, the Madison County Medical Society requested information concerning the procedure to be followed in utilizing services of the Scientific Service Committee. On January 12, 1948, Tazewell County Medical Society expressed an interest. However, at the time this report was prepared neither society has requested assistance.

If every county secretary or program chairman could adopt the procedure of setting up their complete year's schedule, the efforts of the Secretary of the Scientific Service Committee in completing arrangements well in advance of the meeting would prove advantageous to the County Medical Society. It would not only assure better press coverage, but would stimulate better attendance at the meetings.

While the Exhibit of the Illinois State Medical Society originated in the Educational Committee, it has appeared at two large branch meetings of the Chicago Medical Society: North Suburban and North Shore Branches. On both occasions the Secretary of the Committee gave a short discussion on activities and services of the Committee, emphasizing the need for professional cooperation in returning to their colleagues the services created by the Scientific Service Committee.

While the number of county medical societies serviced in this past year would suggest a decrease in activity, the conclusion would be unjust.

Using the news pages of the Illinois Medical Journals as a yardstick, wherein appear the activities of the state's membership under a county division, it is apparent that more county medical societies are holding regular meetings and completing their respective details. It is assumed that the List of Speakers, made available through the Scientific Service and the Postgraduate Education Committee, fulfills its purpose: namely of suggesting names and subjects of physicians who have signified their willingness to participate in the scientific activities of their society. This List of Speakers was revised in January, 1947. Since then approximately thirty-five more names have been added to the card files in the Society's Chicago office.

This Committee views with satisfaction the work carried on. It is ready and willing to expand its services to any county medical society wishing to seek help.

The Committee thinks the per diem of $10 permitted its speakers authorized this past year is most gratifying, and heartily recommends to the House of Delegates that the precedent be continued.

In conclusion, while the Scientific Service Committee feels that the past year has been an active and progressive one, it regrets the fact that an appreciable percentage of our county medical societies are not availing themselves of these services.

Your Scientific Service Committee finds it difficult to adequately express its appreciation of the complete cooperation afforded it by Miss Ann Fox and her associates. The efficiency and regard for details furnished by the Chicago Office at 30 North Michigan Avenue, renders the work of this committee relatively simple.

Respectfully submitted,

Robert S. Berghoff, M. D., *Chairman*, Leo P. A. Sweeney, M. D., *Vice Chairman*, Louis Lamarzi, M. D., Robert J. Patton, M. D., Wade C. Harker, M.D., John H. Gernon, M. D., Charles H. Hulick, M. D., Harry A. Oberhelman, M. D., *Scientific Service Committee.*

REPORT OF THE POSTGRADUATE EDUCATION COMMITTEE

To The Members Of The House Of Delegates:

It is my pleasure and privilege to report to you herewith concerning the activities of the Postgraduate Education Committee.

Under authorization of your Council the Postgraduate Education Commitee sponsored twelve postgraduate conferences during the year 1947-48. These twelve conferences were two more than authorized for the previous corresponding period and fulfills the recommendation of this Committee in its 1947 report to the House of Delegates. The manifest popularity of these conferences is shown in the steady growth from the original four authorized in 1939 to the twelve of the current year. Because of its natural medical resources, the Third Councilor District does not receive a postgraduate conference. Therefore, the twelve were sponsored in ten Councilor Districts. The schedule of conferences is presented as follows:

District	*Date*		*Place*	*Speakers*	*Attendance*
1947					
9	October	2	Marion	5	48
6	October	9	Jacksonville	11	182
7	October	30	Effingham	6	76
1	November	5	Rockford	7	146
5	November	13	Lincoln	7	64
2	December	4	Princeton	7	60
1948					
10	March	11	Murphysboro	10	55
7	March	25	Decatur	9	298
11	April	1	Kankakee	10	93
8	April	8	Champaign	11	190
4	April	15	Kewanee	9	94
6	June	3	Alton		

The following subjects were presented: Syphillis of the Nervous System, Geriatrics, The Placental Stage and Postpartum Hemorrhage, Diarrheal Problems in Infants and Children, Fractures, Surgery of the Stomach, Surgical Problems in Infancy and Childhood, Urology, Infectious Hepatitis, Cancer of the Uterus, Endocrine Aspects of Hypertension, Surgical Treatment of Low Back Pain, Our Prepayment Medical Care Plan, Peptic Ulcer, Dermatoses as Seen in General Practice, Rectal Surgery, Progress in Pediatrics, Tumors of the Kidney, Pathologic Discussion of Tumors, Coronary Disease, Common Fracture Problems with some Reference to Poliomeylitis, Medical Treatment of Hypertension, Surgical Treatment of Hypertension, Surgery of Congenital Heart Deformity, Pathology Basis in Diseases of the Kidneys, Obstetrical Hemorrhages, Penicillin and Streptomycin in Obstetrics and Gynecology, Diagnosis and Treatment of Anal Fissure and Fistula, Occiput Posterior Persistent, Normal Delivery versus Cesarean Section in Eclampsia, Diagnosis and Management of Coronary Thrombosis and Coronary Sclerosis, Present Management of Pneumonia, Treatment of Atrophic Arthritis, Diagnosis and Treatment of Acute Abdominal Emergencies, Sodium Pentothal Anesthesia, Eye Conditions Seen by the General Practitioner, Bowel Obstruction in Infants and Children, Diabetes, Appendicitis in Pregnancy, Abnormal Conditions of the Newborn, Public Relations, The Medical and Surgical Management of Renal and Ureteral Calculi, Electrocardiography, Recent Advances in Hematology, Hip Fractures, Medical Aspects of Biliary Tract Disease, Bronchogenic Carcinoma, Auricular Fibrillation, Ano-Rectal Disease, American Medicine and the Political Scene, Management of Blood Diseases, Rheumatic Heart Disease in Children, The Role of Vagotomy Treatment in Peptic Ulcer, The Exanthemata, Female Endocrines, Is Medical Care Expensive, Surgical Management of Carcinoma of the Large Bowel and Rectum, Physiology of Digestion, Use of Drugs in Allergic Conditions, Diabetic Management, Behavior Problems of Children, Vaginitis, Common Skin Diseases, Endocrine Gynecology, What to Do with Low Back Pain, Varicose Veins, Back Disturbances with Special Reference to the Disc Syndromes, Emotional Problems of Patients with Organic Heart Disease, Uses and Misuses of Sex Hormones, "The Window Trimmer," Nutritional Anemia.

In some instances the attendance at the conferences was disappointing, but the severe weather of the past season may, in some cases, be held accountable. The Committee observes with interest the increasing popularity of shorter presentations by more speakers. The half hour presentation seems to be the preference.

A joint meeting of the Scientific Service and Postgraduate Education Committees was held September 16, 1947, to discuss ways and means of improving services to the respective Councilor Districts and their constituent county medical societies insofar as arranging speakers, releasing publicity and individual notices of meetings to the individual membership. Particular attention was given at this meeting to complete cooperation with Dr. John A. Rogers, executive director, Illinois Division, American Cancer Society, in his plans for holding symposiums on cancer in the Councilor Dis-

tricts of the Illinois State Medical Society. In the year just concluded there has been some conflict in dates, resulting in cancer symposiums being held on the same day as that of our Postgraduate Conferences. To avoid this in the future and to insure continued cooperation with Dr. Rogers, this committee recommends that the respective Councilor Districts establish their dates for Postgradute Conferences through the Postgraduate Education Committee well in advance, thus obviating any confusion. The Secretary notifies Dr. Rogers of all Postgraduate Conference dates as soon as she is notified so that he, in turn, can develop his cancer symposiums with out conflict.

There is a trend toward postgraduate conferences by other organizations. Already there have been some on heart and neurology and psychiatry. It would be helpful if the groups sponsoring the conferences would seek the cooperation of the Postgraduate Education Committee. An effective clearing house would certainly serve the individual doctor better in planning his time.

The Committee reports with pleasure that the text for a postgraduate pamphlet on dermatology has been turned over to the Illinois Department of Public Health, February 13, 1948. This digest is the fourth of a series carried on in cooperation with the department of public health. The series was started in 1944.

Conjointly the Scientific Service, Postgraduate Education and Educational Committees were responsible during the past year for an editorial entitled, "Thank You, Doctor," expressing gratitude to the physicians participating in their respective activities and carrying recommendations to the secretaries and program chairmen of county medical societies to assist the Chicago office in expediting the completion of programs. This editorial appeared in the Illinois Medical Journal February, 1948.

A uniform two-page news release goes to the press in the areas covered for each Postgraduate Conference and all reports indicate that the press coverage for these conferences is better than ever before.

The Committee feels that every attempt has been made to discharge its responsibilities expeditiously. Aware, however, that the local physician whom it attempts to serve has special problems and special needs, the Committee urges comment and suggestions for future service.

Recognizing the tremendous influence of the Postgraduate Conference, your Postgraduate Education Committee recommends to the House of Delegates that these one day conferences be continued. Because the two additional conferences authorized for the first time this year were requested and completed and because we are convinced of the need for this type of postgraduate work, your Postgraduate Education Committee earnestly requests that a minimum of twelve postgraduate conferences be authorized for the 1948-1949 series.

We herewith express our sincere appreciation of the complete cooperation of Miss Ann Fox and her associates.

Respectfully submitted,

Robert S. Berghoff, M. D., *Chairman,* George A. Helmuth, M. D., *Vice Chairman,* Warren H. Cole, M.D., Frank Deneen, M.D., F. Garm Norbury, M.D., Charles O. Lane, M.D., Norbert C. Barwasser, M.D., *Postgraduate Education Committee.*

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

To The Members Of The House Of Delegates:

The Committee on Medical Economics held its annual meeting at the Palmer House, Chicago, Wednesday, May 14, 1947, to draw up a schedule of activities for the coming year.

It was agreed that, to adhere to the principle objective of the Committee—the publication of a monthly article in the Illinois Medical Journal, it was necessary to develop a backlog of material. To accomplish this, the fifteen members of the committee submitted from one to three titles that they considered worthy of discussion. Each committee member indicated the title that he preferred to prepare for immediate presentation. All the titles were mimeographed and returned to the respective members of the Committee so that each was informed of the proposed articles.

Deadlines were set for each article and on receipt, in the Chicago office of the Illinois State Medical Society, were mimeographed and returned to the respective members of the committee for comments and approval. The comments were then returned to the author of the article for incorporation.

The procedure has proven so successful that an article on a different medical economic subject has appeared monthly in the Illinois Medical Journal since August, 1947. The titles submitted in the original list were "The Patient, A Human Being," "Trends in Laboratory Service in Hospital Practice," "The Extension of Pathology into the Medical. Practice of Rural Communities in Illinois," "Unnecessary Operations," "Economic Aspects of Medico-Legal Testimony," "The Pre-Employment Examination and Its Economic Significance," "The Purchase of Medical Care By State Governmental Agencies," "Medical Services for Rural People," "The Purchase of Public Health Service," "Evaluation of Post-graduate Medical Educational Facilities in Illinois," "Analysis of the Hospital Facilities in Illinois," "Role of the State Medical Society in Incentives for Postgraduate Study," "Recognition for the Doctor Who Best Knows His Business," Pre-Marital Tests and Marriage Counseling," "Keeping Up with the Times," "Facilities in Illinois for Planned Parenthood Information," "Medical Trends of Today," "Attitude of Hospitals vs. Medical Profession," "Some of the Dangers Inherent in Government Controlled Health Insurance Plans," "Can Anything Be Done about Reducing Costs of Hospitalization?" "Doctors' Fees Only Incidentals in the Overall Cost of Medical Care," "Influence of Veteran Hospitals on the Private Practice of Medicine," "Clinic or Group Practice in Illinois," and "Education of the General Practitioner."

Since the inauguration of this procedure in preparing material for publication, the following titles appeared in the Illinois Medical Journal, some of which

were not included in the original list: "The Extension of Pathology into the Medical Practice of Rural Communities in Illinois," August, 1947; "Training of Residents in Basic Sciences," September, 1947; "To Each His Own," and "Illinois State Hospital Needs," October, 1947; "Unnecessary Operations," November, 1947; "The Selection of Medical Students," December, 1947; "Trends in Laboratory Service in Hospital Practice," January, 1948; "Continuation Education for Physicians," February, 1948; and "Partnerships in Medical Practice," March, 1948.

During the time this report was prepared, the following titles were scheduled for publication in subsequent issues: "Some Inherent Difficulties in Health Schemes Sponsored by Any Government," "Medical Education of the General Practitioner," "The Patient, a Human Being," and "Pre-Marital Tests and Marriage Counseling."

In some instances, guest editorials were requested by physicians who were not members of the Committee but who were active in fields that yielded material of a wide medical economic philosophy. The titles of the two guest editorials submitted were, "Medical Care for the Recipients of the Illinois Public Aid Commission," and "Illinois State Hospital Needs;" the latter appeared in the October, 1947 issue of the Illinois Medical Journal.

During the past year there have been some changes in the membership of the Committee. Members who resigned because of pressing activities in other committees were Dr. John R. Vonachen, Peoria, and Dr. William J. Bryan, Rockford. New Committee members include Dr. Hubert L. Allen, Jr., Alton; Dr. Edwin F. Baker, Lewistown; and Dr. Walter M. Whitaker, Quincy.

It is noteworthy that some Committee members extended their obligation of contributing one article a year by submitting two and three articles. Other members of the Committee did not submit the one article of their preference. Even with this in mind, the Committee feels that the procedure followed during this past year of preparing a backlog of material was successful. It recommends that the system be continued another year.

The advances in medicine form two avenues of approach to the changing medical economic field. The Committee feels the need for a steady analysis of the changing picture. Hospital regulations, advancing costs, variation in medical practice with resultant encroachments by so-called experts in economic research, all tend to affect the high standards of qualified medical practitioners. With this in mind, the Committee earnestly recommends a closer cooperation in the activities of the Committee on Medical Service and Public Relations whose activities reflect the overall attitude of the medical membership as a whole and encompass the individual activities of the Scientific Service, Postgraduate Education and Educational Committees in making available speakers to scientific and lay groups.

The Committee also wishes to extend its sincere thanks to Miss Ann Fox for her extensive efforts during the past year. It has been through her work as executive secretary of the committee that our responsibilities have been met.

The final meeting of the committee for the calendar year is being held Monday, May 10, 1948.

Respectfully submitted,

Chauncey C. Maher, M. D., *Chairman,* V. Thomas Austin, M. D., Emmet B. Bay, M. D., Milton E. Bitter, M. D., Carroll Birch, M. D., Thomas C. Browning, M. D., Roland R. Cross, M. D., George Halperin, M. D., Edwin S. Hamilton, M. D., Ford K. Hick, M. D., Edwin F. Hirsch, M. D., Jay McDonald Milligan, M. D., Harry A. Oberhelman, M. D., Marie Wessels, M. D., *Committee on Medical Economics.*

REPORT OF THE CHAIRMAN OF ADVISORY COMMITTEE STATE COMMISSION ON THE CHRONICALLY ILL

To the Members of The House of Delegates:

Nearly two years ago a commission was appointed by the Governor based on recommendations made in the Illinois State Legislature that a commission be appointed to study the problems of the chronically ill in Illinois. This commission asked that several advisory committees be appointed to help guide it and one of them was from the State Medical Society.

The commission was in a position to inaugurate legislation of a type of which organized medicine might or might not approve and it was felt that the advisory committee should study the problems with them rather carefully. There were several meetings of this committee with the members of the commission and we found them to be very intelligent and very interested in the problems of this type of individual. It was noted that the chronically ill are the ones who fill the state institutions and who also place the largest burden on the taxpayers when it comes to local medical care expenses. To the surprise of all of us, it was found that only one-third of those who are listed as chronically ill are over the age of 65 years. The others are the cardiac cripples, those with chronic osteomyelitis, the spastic paraplegics, those who have had infantile paralysis, as well as many others. Incidentally, this had nothing to do with the insane.

One of the recommendations to the state commission was that counties be encouraged in the development of county nursing homes for the care of such cases and that funds be made available from the state for assistance in such homes. A very friendly working arrangement was made with members of the commission by the committee and it was felt that the two were mutually helpful. The committee was able to forestall attempts toward adverse legislation and to encourage legislation of the type that might be beneficial. However, in the final rush

of bills at the end of the last session of the legislature and with the attempt of the administration to effect as much economy as possible, the recommendations of the commission did not receive final legislative attention. This may be brought up at the next term of the legislature, and if the recommendations of the commission go through, it will be found that nothing inimical to the interests of the medical profession or the health of the public has been introduced.

Respectfully submitted,

Everett P. Coleman, M. D., *Chairman, Advisory Committee, State Commission on the Cronically Ill.*

REPORT OF THE FIFTY YEAR CLUB COMMITTEE

To the Members of The House of Delegates:

In 1937, the Illinois State Medical Society realized that there were a number of physicians in the state who had engaged in the practice of medicine for fifty years or more. Realizing that many of them had dropped their active membership in the Society and were more or less neglected, the Society conceived the idea of organizing a Fifty Year Club and honor these old physicians by making them eligible to membership. Any physician who has been practicing fifty years and is recommended by the County Medical Society in the district in which he resides is eligible to membership in the Club. Since the organization of the Club, not less than 550 have been inducted into the Club. At the present time the Club has a membership of 202 downstate and 148 in Chicago, making a total membership of 350.

Every year when the Illinois State Medical Society meets, all the members of the Fifty Year Club are invited to attend a complimentary banquet given by the State Society. Last year no less than 85 members attended and with other guests there were no less than 100 at the banquet. Short impromptu talks were given by various members present, old friendships were renewed and a very enjoyable hour was spent.

We now have the largest membership in the history of the Club and invitations will be sent to all members, and we expect a larger attendance this year than in any previous year.

Since the organization of this Club, many of the old members who had long since ceased to attend the State Medical meetings now look forward to the State meetings and are regular attendants.

Andy Hall, M. D., *Chairman,* Channing W. Barrett, M. D., E. H. Ochsner, M. D., H. O. Munson, M. D., *Fifty Year Club Committee.*

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

To the Members of The House of Delegates:

Your committee during the past year has maintained a constant alertness to changes that are taking place in the field of medical service in industry. At no time has there been a greater need for the medical profession to assume its responsibility to provide a proper standard of health conservation for industrial workers.

There is an increasing need of organizing a fairly comprehensive plan of health protection and individual hygiene for small industrial establishments —those employing fewer than 500 workers. There is need of a more forthright understanding by the rank and file of medical practitioners of the employer-employee implications in problems of industrial health. There is need of alertness by all physicians in the industrial field to keep occupational medicine as a purely scientific, fact-finding and service specialty—unprejudiced by ulterior interest.

The increased participation by management in mass x-ray surveys, cancer detection, study of alcoholism and venereal disease control demonstrates the interest of our industrialists in problems of health only casually related to employment. Physicians should have a clearer understanding of the employer's viewpoint on these particular matters.

The threat of establishing medical practice on a regimented socialized scale is still present. With doubt of the stability of our industrial economy in the future—one of the first groups to which this type of medical care would appeal is the industrial workers on short hours and short pay. A proper standard of industrial medical practice might be the "saving grace."

The committee wishes to express its appreciation to the various members of the Illinois State Medical Society who have participated with us in meetings, discussions, conferences and publication of papers on special aspects of Industrial Health.

Respectfully submitted, Joseph A. Chivers, M. D., *Chairman,* Richard J. Bennett, Jr., M. D., C. O. Sappington, M. D., Harold A. Vonachen, M. D., R. I. Barickman, M. D., *Committee on Industrial Health.*

REPORT OF ADVISORY COMMITTEE SURVEY ON CHILD HEALTH, AMERICAN ACADEMY OF PEDIATRICS

To the Members of The House of Delegates:

The Advisory Committee of Child Health Services has held no regular meetings.

The Survey on Child Health Services conducted by the American Academy of Pediatrics has been completed and is now being written up preparatory to submitting the data to this committee.

The data will be broken down into councilor districts and analyzed so that it can be used at local levels. It does not appear likely that this will be possible before the annual meeting.

Respectfully submitted, John F. Carey, M.D., *Chairman,* Gerald Cline, M. D., W. L. Crawford,

M.D., George L. Drennan, M. D., Julius H. Hess, M. D., Eugene T. McEnery, M. D., *Advisory Committee, Survey on Child Health Service.*

REPORT OF COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

To the Members of The House of Delegates:

The House of Delegates in May, 1947, at the request of this Committee, removed the requirements of including certain principles and objectives as part of the Illinois Plan for Voluntary Prepayment Medical and Surgical Care and thus placed on the Committee the responsibility and necessity of making a number of changes therein.

The Chairman of the Council has appointed a medical advisory committee to confer with insurance carriers, to conduct administrative affairs and to consider and take appropriate action on such problems or controversies as may arise between or among carriers participating in the plan, the public and the medical profession. The personnel of this Committee has been identical thus far with the Committee on Voluntary Prepayment Plans.

In order to enhance the effectiveness of the Illinois Plan, the Committee recommends to the House of Delegates that it urge the members of the Illinois State Medical Society to accept as payment in full the benefits provided for services rendered to persons in the low income group. A public pronouncement to this effect may have a very wholesome influence in regard to the participation in the Plan by many additional desirable insurance companies as well as serve notice that the Illinois Plan has as one of its objectives to help make available for the lower income groups, good voluntary prepaid medical and surgical insurance with care being provided by the physicians of their own choice.

Coverage under the Illinois Plan consists of reimbursement for charges made by physicians for surgical and medical care in the home, office or hospital, beginning with the first call in case of accident and with not later than the third call in case of illness. Benefits for obstetrical care are provided irrespective of hospital confinement.

Insurance companies are required to submit for approval policies providing all these types of coverage for the insured and his dependents but may also submit policies providing only parts of this combination with or without coverage for dependents.

Only insurance companies licensed to do business in Illinois are eligible to participate in the Plan and no policy or contract is considered for approval by the Committee unless the same shall have been approved by the Illinois Department of Insurance.

All advertising and promotional literature involving the Society's name is submitted to the Committee and is subject to disapproval upon reasonable notice to the company.

Conferences have been held with representatives of the Conference Committee on Health Insurance which was formed by representatives of several trade associations and which is said to represent the companies that write more than 90% (ninety per cent) of the life insurance in the Middle West and in the eastern seaboard states. This Committee was designated to cooperate with the Illinois State Medical Society in the development of prepaid medical care plans. Much discussion has been held with the Conference Committee pertaining to the low income group and the desirability or necessity of establishing an income level. If the income of the policyholder is below the stated level or if he falls in the low income group, the insurance companies feel that the benefits he receives should be accepted as payment in full by his physician.

In the absence of a stated income level, it has been suggested that there might be encouragement for the physician to charge the patient in this group more than he would charge if the patient did not have insurance. The Committee does not subscribe to this thought and feels that this is a matter of education and policing among the members of the medical profession. The insurance companies do not wish to be criticized in this action by being placed in the position where they might be accused of encouraging a physician to charge more than his usual fee.

The Committee maintains that it does not deem is practicable at this time to institute such a stated income level in Illinois because of the differences in the rural and metropolitan populations.

The Committee on Prepayment Plans feels that the problem involved in the fees to be charged people in the low income group is one that has to be solved by the members of the medical profession, in whom the Committee has the utmost confidence. An effort is being made by the Committee to acquaint members of the Society at postgraduate meetings, County and Branch Society meetings and hospital staff meetings and conferences, with the desirability and necessity of accepting as payment in full for services rendered the benefits received by those insured who belong to the low income group. The members are urged to adhere to this principle so that one of the main objectives of this program may be accomplished. It is the considered opinion of the Committee that the wholehearted acceptance of this principle by the profession could do much to obviate the necessity of any compulsory scheme that might be proposed.

A new table of benefits has been adopted by the Committee and made a part of the Illinois Plan. This fee table corresponds to that of Rhode Island; its adoption disposes of serious objections on the part of some insurance companies and also provides a much more modern and comprehensive schedule of minimum benefits.

A new pamphlet describing the Illinois Plan has been prepared and it is the intention of the Com-

nittee to have them distributed as widely as possible throughout the State. It is proposed to utilize the cooperation and facilities of the Educational, Postgraduate and Medical Service and Public Relations Committees, the County Medical Societies, Branch Medical Societies and hospital staff groups to disseminate information regarding the Illinois Plan.

At the time of this writing, about 15,000 contracts have been sold in Illinois and it is anticipated that, with the attitude of some of the old-line companies changing from one of interest to that of participation, this number will become greater in the near future.

The Committee feels that a report of definite progress can be made and that the most difficult part of the groundwork has been laid on a legitimate and sound basis for the success of The Illinois Plan. It has tried to benefit by the experience of State Medical Societies with similar set-ups and is sure that progress henceforth will be much more rapid. Again it wishes to urge the members of this Society to accept as payment in full for services rendered the benefits obtained by those policyholders for whom the payment of a greater fee would be a hardship.

The Committee has had the benefit of the advice of the legal counsel of the Illinois State Medical Society, who has participated in practically all of the meetings and conferences that have been held, as well as the technical advice and opinion of an insurance executive who has no connection with or interest in any individual insurance company. In addition the Public Relations Counsel of the Illinois State Medical Society has devoted much time and effort to the activities of the Committee, including the preparation of the new booklet in cooperation with the legal counsel. The Secretary and Assistant Secretary of the State Society have been active participants in this work and because of that fact have undoubtedly saved the Society considerable expense.

The Chairman is grateful to all the members of the Committee for their unselfish contributions in time and thought and it is a pleasure to acknowledge publicly his gratitude and appreciation to them.

Respectfully submitted,

Percy E. Hopkins, M. D., *Chairman,* Warren W. Furey, M. D., Harold Miller, M. D., Edwin S. Hamilton, M. D., Charles P. Blair, M. D., David B. Freeman, M. D., E. G. Quattlebaum, Jr., M. D., Irving H. Neece, M. D., Walter Stevenson, M. D., Harold M. Camp, M. D., *Committee on Prepayment Plans for Medical and Surgical Care.*

DR. HOPKINS: The Committee has a very short supplementary report to this effect:

The seal of acceptance of the Council on Medical Service of the American Medical Association was awarded to the Illinois Plan on April 16, 1948. This Seal of Acceptance now appears on the descriptive literature of the Illinois Plan.

Four old-line insurance companies have recently signified their intention to submit contracts in conformity with the principles required by the Illinois Plan, one company already having submitted contracts which will be considered at the next meeting of this Committee.

REPORT OF THE MATERNAL WELFARE COMMITTEE

To the Members of The House of Delegates:

The Maternal Welfare Committee of the Illinois State Medical Society wishes to report the following activities during the year 1947-48.

Three meetings have been held at which various subjects concerned with Maternal Welfare in Illinois were discussed. In connection with the last annual meeting of the Illinois State Medical Society a luncheon was given in cooperation with the State Department of Public Health at which the development of the plan for the study of maternal deaths was discussed.

At the summer meeting of the Illinois Obstetrical and Gynecological Society a symposium on infant diarrhea was held and data presented on various epidemics which had occurred the previous year in Illinois.

Your Chairman with Doctor Cross of the State Department of Public Health submitted a plan of the Maternal Welfare Committee for the study and recording of maternal deaths in Illinois, which was approved by the Council, and the Committee is now at work analysing the reports which are being sent in from the representative of the State Department of Public Health who investigates circumstances surrounding the deaths. The reports are anonymous as far as the hospitals and doctors handling the cases are concerned. The results of the analysis of the Maternal Welfare Committee are retained in the files of the Chicago Office of the Illinois State Medical Society.

The third meeting was held at the University of Illinois in connection with the annual clinical meeting of the Illinois Obstetrical and Gynecological Society and plans for better organization of obstetrical service in hospitals and for strengthening the membership of the Maternal Welfare Committee in various counties with the assistance of the councilors from their districts. The Committee also recommended that where facilities for fetal autopsies were available that neonatal deaths be carefully studied and the results recorded.

F. H. Falls, M. D., *Chairman,* A. B. Owen, M. D., J. T. O'Neill, M. D., W. R. Young, M. D., Ralph R. Loar, M. D., Milton E. Bitter, M. D., Lee O. Frech, M. D., Carl Greenstein, M. D., Willis I. Lewis, M. D., W. C. Scrivner, M. D., James C. Carey, M. D., Committee on Maternal Welfare.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION

To the Members of The House of Delegates:

The report of your committee this year is, in a sense, one of progress and it contains results of the past year which are both good and bad. In most ways, your committee feels that progress has been made during the past year in the care of Public Aid recipients and in safeguarding the interests of the medical profession. On the other hand, some unsatisfactory things have developed and while the committee has been able to solve some of these, many of them will be problems of the type which may always confront us. The program has been abused many times by Public Assistance recipients and on a very few occasions, by doctors themselves. Most of these latter cases have been due to a misunderstanding rather than a definite abuse, but this is not always the case. The committee has been able to assist the commission in the solution of some of these problems and has tried to make the situation clear to the membership at large insofar as it could. One recent method has been to invite Chairmen of various County Committees to attend the regular meetings held by this committee in Chicago so that they will be able to see what the committee is attempting to do and carry that information first hand to their own communities. This plan is in its infancy and it is hoped that it will be found practical.

Some progress has been made last year in the question of fees for surgical cases. In the two years prior to this some medical fees had been raised, but surgical fees had remained at $50 for any type of major case. This year they have been raised to $75 for major cases and a maximum of $100 is allowed for such things as thyroidectomy, radical breast amputation, major stomach or bowel resection, gallbladder surgery, prostatic surgery if complete, and fractures of the hip. The amount allowed for these recipients has been increased from a maximum of $40 per month, with only $10 of this being allocated to medical care, to $75 a month when the patient is in a hospital or institution which is not tax supported. In addition, one of the worst abuses was in the event of the death of the patient after a long terminal illness, when nothing could be paid the doctor for services which might have represented a great deal of time and effort. In the past year it has been possible to get direct payment to the doctor from the department for all cases of terminal illness.

In the majority of counties throughout the state, the local County Medical Advisory Committees are functioning with increased efficiency. In a few they are not doing much work or are not in existence; but in a community where an advisory committee is functioning satisfactorily, they are accepting the responsibility of medical leadership and are controlling the problems quite satisfactorily. They are far better able to handle local problems than case workers would be and of course, much better than the general committee at its monthly meetings when they have problems submitted to them about which they know nothing whatsoever of the local angle. It is to be hoped that, as time goes on, these local committees will take over entirely all the problems that come up in their own communities.

Your state committee meets regularly, usually at the weekend when the Council meets; but in addition, urgent problems are cared for by mail. It tries to limit its activities to matters of general policy but has many concrete examples submitted which could be cared for better by the local committees who know more about the local situation.

The problems that arise throughout the state are largely due to misunderstanding. Many doctors who have not gone through the days of the Illinois Emergency Relief Commission do not appreciate that this is a limited service with limited funds. Also, that it is much more liberal than similar programs in most other states. Some of them cannot understand the need for substandard fees for these low income group individuals, and do not realize that these fees are higher than many private fees were during the depression. One of the abuses of this program has been on the part of the patients who were paid by the state with funds from which they are supposed to pay their medical bills, and fail to do so. Investigations have been conducted in several portions of the state which indicate that very seldom does this lack of payment run as high as 10%, but it is still an abuse and the department is doing what it can to correct it by educational means.

The Illinois Public Aid Commission has had to take care of the financial problems, including medical, of the group on Aid to Dependent Children, the Blind, and the Old Age Assistance Recipients. The first two are on a sound financial basis, but the Old Age Assistance program is possibly going to run short of funds at the end of the biennium. The total estimated need was thought to be $212,000,000 for a two year period of time; but the legislature, with ideas of economy in mind, arbitarily reduced this to $175,000,000, leaving a $37,000,000 deficit. The Old Age Assistance program may possibly run short on this account before the two year period is up. Should this occur, medical funds will suffer along with the remainder, and if a special session of the legislature is called to take care of a deficiency appropriation, they may possibly limit medical funds which is a thing that would not serve the interest of the pensioners to their best advantage. The department hopes to avoid this and is trying to economize in every way possible. Since the number of Old Age Pensioners has not increased very much, but the number of them seeking

medical care has doubled in the past two years, therefore medical expenses are being watched closely also. It is found that, in many instances, the cost of drugs has been out of proportion to other phases of medical care. For example: a doctor seeing a patient, say for an office call, for which he receives $1.50, may prescribe from $5 to $8 worth of drugs and this may be repeated in a week. Because of this problem, the committee has recommended to the local County Advisory Committees that they see if it is possible to get their members to use USP and NF preparations when feasible. This is simply a suggestion with the hope that it can be followed out in some communities as it has been in others. In a few places where this has been tried, it has worked very satisfactorily; in others, it has not.

An additional problem has come from the fact that some doctors have asked that the department pay the doctor directly for his services to the Illinois Public Aid Assistance recipients. When this program was first brought out, a majority of the doctors who discussed it were opposed to direct payment on the part of the state or federal government. They felt that it placed the state in between the patient and the doctor, but more recently there has been a change in this trend and an increasing number of doctors are asking for direct payment. This has been taken up by your committee with the Illinois Public Aid Commission.

The local commission is very friendly to the medical profession and is anxious to do what the doctors want when it is within the power of the commission to do so. However, the state funds which are matched by federal funds have to be dispensed according to certain federal rulings, and one of these is that any form of aid must be given directly to the recipient of such aid. If direct payment is made, then the federal matched funds are withdrawn. The reason a direct payment can be made to the hospitals, or in terminal illnesses, is that since these constitute a smaller part of the matched funds, the state has felt that it could forego them and pay directly, but these payments are all made with state funds and not with federal aid. The I. P. A. C. is also desirous of having direct payments made and has, on several occasions, attempted to get bills through congress which would permit of this being done. So far, they have been unsuccessful, but there is a possibility that direct payment may become a part of this program in the future.

The drawbacks of this program are the fact that the work has to be done on a substandard fee schedule, that it seems necessary to safeguard the state funds, and with the danger of the funds running out before the biennium is up, that it seems necessary to cut down the cost of drugs prescribed or dispensed. This is a direct interference with the doctor prescribing for his patient, and the committee has attempted to interfere with this as little as possible, but due to certain abuses has been compelled to take certain actions to control problems which seem apt to get out of hand from the standpoint of drug costs.

The chief advantage of the program, from the standpoint of your committee, is the fact that being a federal law, the program will go ahead whether we work with it or not; but that if we fail to work with it, it will very quickly develop into a bureaucratic plaything under non-medical control and without the benefit of medical advice or supervision. It seems best to keep it under medical control insofar as possible to give the recipients of this aid the best in medical care that can be furnished, and to have a committee which attempts to protect the interests of its members as well as those of the patients to the best of its ability. We feel we have been successful in this way to a very considerable degree. We realize we have been unsuccessful in some instances and that there are many improvements yet to be made but as we learn more about the program and more as to how it can be satisfactorily administered, we feel that the accomplishments far outweigh the drawbacks.

Respectfully sumitted, E. P. Coleman, M. D., *Chairman,* Harold M. Camp, M.D., Harlan English, M.D., Percy Hopkins, M.D., Irving Neece, M.D., Walter Stevenson, M. D., Edwin S. Hamilton, M. D., Julius Hess, M.D., *Advisory Committee to Illinois Public Aid Commission.*

REPORT OF THE PERMANENT HISTORIAN

To The Members of The House of Delegates:

The history of early medicine in Illinois is far from complete. In fact only a beginning has been made. For example, the medicine of the early Illini Indians following the French period, and of the pioneer period of the Northwest Territory, still offers a most fertile field for the medical historian.

This is not to say that nothing has been done.

Dr. L. H. Zeuch, cooperating with a committee of the Illinois State Medical Society in 1927, issued Volume I "History of the Medical Practice in Illinois" in which the pertinent facts relating to the practice of medicine in the State are set forth up to approximately the year 1850.

About the same time (1927) the State Department of Health issued "The Rise and Fall of Disease in Illinois," a contribution to the history of public health in the State, written by Rawlings cooperating with a State committee.

Again, about the same date (1925) Dr. George Weaver issued a monograph on "The Beginnings of Medical Education in and near Chicago." The institutions and the men covered the history of the educational periods of the early colleges of the state, together with valuable biographical data of many eminent physicians of the early years in Illinois.

From time to time other important contributions dealing with historical topics and biographical sketches in the State have been issued, especially in the Illinois State Journal and in the Bulletin of the Society of Medical History of Chicago. Several appeared about the year 1927, which happened to have been approxi-

mately the 75th anniversary of the Illinois State Medical Society and the 50th anniversary of the organization of the State Health Department, both of which events naturally are significant landmarks in the history of the State.

Zeuch's volume was issued by the State Society as Volume I of a continuing series of historical contributions, and it was then understood that forthcoming volumes would follow from time to time.

During the past year, the Society has decided to issue such additional volumes, and a committee has been appointed with instructions to proceed with the project. The Committee personnel is as follows:

James H. Hutton, Chairman; J. J. Moore, David J. Davis, Charles P. Blair, D. D. Monroe, C. Ellsworth Black, E. H. Weld, Harold M. Camp. James C. Leary and Frances Zimmer meet with this committee.

Several meetings already have been held, two in Chicago, one in Monmouth and one at Springfield in the State Historical Library. Reports of these meetings have been noted in the current issues of the Journal.

The Committee has agreed to prepare a second volume as soon as feasible following the plan of Volume I, but with modifications and limitations. This will be done in close association with the organized County Societies of the entire State. For this purpose the Secretaries of the local societies, physicians and others qualified to furnish historical data, and the many Woman's Auxiliaries of these societies will be called upon to aid in the project. It is well known that a very large amount of information bearing on medical history already has been assembled by the County Societies as well as by physicians and others interested.

One of the first efforts of the committee will be the assembling, and indexing, and the systematic coordination of this truly vast amount of data; all of which must be done before the actual writing of the history can begin. For much of this work, naturally, the office of the State Secretary (Dr. Camp) will become the pivotal center.

In addition to this more or less systematic plan designated to cover the State, the committee feels it will be necessary to issue additional volumes (or supplements or appendices) from time to time, to deal with special subjects and fields which stand apart, as it were, from the general history of the practice of medicine. For example, it would seem that a special section or volume will be necessary to adequately cover the medical records of the Civil War period in Illinois; possibly later, similar ones to cover subsequent war periods. Also such subjects as the history of medical education, of hospitals, both private and public, of State and local medical organizations, of State medical and health legislation, of medical licensure, of quackery and cults, of church and religious organizations, of epidemics, of the beginnings of the various specialties in the State, etc., as well as others which later may seem desirable. Also, a complete biographical directory of all Illinois physicians, both past and present, is highly desirable.

Medical history is progressive and dynamic. It is never-ending and therefore cannot be confined in advance to any predetermined or fixed pattern or program.

Plans are under way by the Committee for an Exhibit on the History of Medicine in Illinois at the next State Meeting. (May).

D. J. Davis, M.D.,
Permanent Historian.

REPORT OF THE COMMITTEE ON MILITARY AFFAIRS

To The Members of The House of Delegates:

Two stated meetings of the Veterans Service Committee were held during the past year. The first meeting was held at Springfield, August 10, 1947, with a majority of members present. In addition to bringing all members of the Committee up to date regarding the activities since the last Annual Session of the Illinois State Medical Society, a procedure was outlined which, it was thought, would assist Illinois physicians still in service in their return to civilian status and the re-establishment of their practice. This plan also included the physician who was being separated from service and who desired to establish his practice for the first time in Illinois. It was subsequently reported that this program, in its essential points, was being carried out effectively through the Office of the Secretary of the Illinois State Medical Society.

It was the unanimous opinion of the members attending this meeting that there was a scarcity of vocal representatives of organized medicine concerned with the deliberations of veterans' organizations in Illinois. Certain veterans' organizations supported bills introduced in the last Assembly of the Illinois legislature whose passage would have permitted the expansion of the irregular practice of medicine within the State of Illinois.

Because of this trend, it is strongly recommended that more interest and action be exercised by the physicians of Illinois who are members of their local service organizations. It is, therefore, earnestly recommended that organized medicine throughout the state secure staff representation in the veterans' service organizations or establish liaison locally with these organizations in order that the interests of organized medicine within this state may be broadened and further developed. This recommendation, if widely carried out, would enhance the public relations of the Society representation in civic affairs and promote the public welfare and health of the citizens of Illinois.

The second meeting of the Committee was held March 3, 1948 in Chicago, at the Palmer House, with the entire membership present. The limited scope of the present activities of this Committee was reviewed. The purpose and scope of the Council on National Emergency Medical Service of the American Medical Association was discussed. A resolution was passed requesting the Council of the Illinois State Medical Society to further extend the duties of the Veterans Service Committee to include those advanced by the Council on National Emergency Medical Service of the American Medical Association which were, or

J 27931

would be, applicable at the state level. It was further determined that the name of the Veterans Service Committee be changed in such a way that the increased scope of its activities would be indicated. The following resolution was therefore adopted:

WHEREAS, the disturbing aggressiveness of certain powers and political forces may affect the health, safety and welfare of the peoples of the world and the United States of America in particular, and

WHEREAS, it is believed that definite steps should be taken to guard the health, safety and welfare of our Nation, and

WHEREAS, we believe that it is the obligation of organized medicine to formulate a program of preparedness for the conservation of the lives and health of the citizens of the State of Illinois, therefore

BE IT RESOLVED: That the name of the Veterans Service Committee shall be changed to the Committee on Military Affairs of the Illinois State Medical Society and that its duties be extended to include not only the veterans' problems but every problem pertinent to national and local defense which may devolve upon the medical profession within the state of Illinois.

This resolution was presented by the Chairman of this Committee to the Council of the Illinois State Medical Society, March 7, which body approved the resolution and the extension of activities of this Committee, stipulating that the Committee shall henceforth be known as "The Committee on Military Affairs and Emergency Medical Service."

Because of the many dinner activities occurring on the first night of the Annual Meeting and the small number of veteran physicians who attended the Veterans Service Committee dinner in 1947, it was recommended by the Committee, and approved by the Council, that the annual dinner of this Committee be combined with the Secretaries' Dinner on the first day of the Annual Session, Monday, May 10, 1948. Dr. Harold Lueth, Dean of the University of Nebraska College of Medicine, Omaha, formerly a member of this Committee, has been invited to be the speaker for this combined dinner.

The Veterans Service Committee was the outgrowth of a Contact Committee with the American Legion created in 1931. In March 1932 the Committee was broadened to include all ex-service men's organizations because of the then existing interest in veterans' legislation. (The Illinois Medical Journal, July 1932, p. 27). In this year, 1932, official action changed the name from Contact Committee to Veterans Service Committee so "that the desired contact could be changed to include the Veterans of Foreign Wars, the Disabled Veterans' Association, and the Spanish War Veterans' Association." Dr. Thomas P. Foley, then Chairman, commented in his report: "It is hoped by this change that the friendly relation established with the American Legion may be extended to these organizations."

Another excerpt may be cited from the report which is considered of paramount importance in the year 1948: "The danger to a committee of this kind is that in the maze of material it studies that the practical side of interest to the average physician may be slighted."

This interpolation, including the original purpose of the first committee and the adoption of the recent resolution signifying a need for cooperation with the Council on National Emergency Medical Service of the American Medical Association as it applies to the State of Illinois, is presented to indicate the active medical interest in military affairs since the creation of the first Contact Committee in 1931.

The Council on National Emergency Medical Service of the American Medical Association conceives its general purpose to be:

"The development of proper, logical and timely advice for presentation to the Board of Trustees of the American Medical Association with reference to the medical and associated problems involved in the mobilization of our nation's armed forces, industry, agriculture and civilian population in time of a national emergency.

"This council is therefore required to make a continuous planned and coordinated study of these numerous problems associated with the mobilization of our nation's manpower, resources and materials.

"It is necessary therefore for this council to maintain direct and continuous contact with other civilian and governmental medical and allied organizations and agencies as well as with those agencies and organizations involved or responsible for the planning and operation of our national defense in its broadest term."

The Chairman of this Committee met with the Council on National Emergency Medical Service of the American Medical Association on April 5-7 as the authorized representative of the Illinois State Medical Society. This session had not yet been held at the time this report to the House of Delegates was prepared. A report will be made subsequently to the Council.

It is with sorrow and deep sense of gratitude in having worked so closely with him that we inform the membership of the Society that this Committee lost a very active and conscientious member in the sudden death of Dr. M. Herbert Barker on August 12, 1947; only a few days following the Springfield meeting of this Committee and which he attended. Dr. Barker's counsel and judgment have been missed in the deliberation of this Committee. The Annual Report of this Committee is dedicated to the memory of Dr. Barker by unanimous action of the Committee.

Dr. Leo P. A. Sweeney, Chicago, was appointed by the Council to serve during the unexpired term of Dr. Barker's appointment.

Your Committee desires to express its gratitude to the officers, members of the Council and various members of the Society who have, by their wise counsel, assisted this Committee in serving the Illinois State Medical Society during the present year, and requests the continued cooperation during the expanding activities of this Committee.

Respectfully submitted, Earl H. Blair, M.D., *Chairman,* Pliny Blodgett, M.D., F. T. Brenner, Jr., M.D., Gilbert H. Edwards, M.D., Philip Lewin, M.D., Ken-

neth H. Schnepp, M.D., Leo P. A. Sweeney, M.D., *Committee on Military Affairs.*

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

To The Members of The House of Delegates:

The following report is presented with a deep sense of appreciation for the laudable activities of the Woman's Auxiliary to the Illinois State Medical Society. It has been helpful to us since its establishment in 1927.

During the fiscal year under the capable leadership of its President, Mrs. John Soukup, assisted by her able corps of officers, much has been accomplished to abet the objectives of our Society.

The writer was invited to attend the annual Conference for County Presidents and other officers held in Chicago last November. Various reports were received and duly considered, and interest stimulated in the following activities:

Organization was considered of paramount importance. As a result, more than 200 new members have been secured.

The Benevolence Fund has been augmented by an amount exceeding $2,000.00 by means of benefit meetings.

Public Relations have been improved by contacting the laity in most counties, through the local organizations. As part of this educational program, our plan for Prepayment Medical Care has been accorded special attention.

Subscription sales of HYGEIA have progressed favorably.

The Legislative Chairman, Mrs. George E. Kirby, has been alert and in close contact with the National Chairman.

A new activity assigned to the Auxiliary by the Council, namely searching for historical data to assist in the completion of The History of Medical Practice in Illinois, is receiving due attention.

An original and most worthy endeavor of the President, was the compilation of a brochure entitled, "Questions Answered About an Auxiliary." This is informative and deserves honorable mention.

In conclusion, we believe the Woman's Auxiliary is a very important section of our Society structure. Their endeavors deserve our support and heartiest commendation.

Respectfully submitted, Darwin B. Pond, M.D., *Chairman,* Rollo K. Packard, M.D., E. G. Beatty, M.D., Harold M. Camp, M.D., *Advisory Committee to The Woman's Auxiliary.*

DR. POND: In the annual report there is a small matter but it has a direct bearing on one of the reports of this afternoon. I want you gentlemen to know that the Auxiliary raised over $2500 this year, and of that amount over $2000 was given to the Benevolence Fund.

REPORT OF THE COMMITTEE ON TUBERCULOSIS

To The Members of The House of Delegates:

The Committee during the past year has had no major problems to confront it but has followed the general trend of all the major organizations that have had a part in the campaign of eradicating tuberculosis. Although tuberculosis and mortality statistics for 1947 are not available, present indications are the rate will be the lowest ever recorded in Illinois. For the first ten months the mortality was lower by 8% than that for the previous year. Up to November 1st, 2,320 tuberculosis deaths had been recorded in Illinois against 2,531 for the same period in 1946. From these figures it will be seen that it would be an error to underestimate the seriousness of the tuberculosis problem in Illinois nor to minimize the task that lies ahead in eradicating the disease as a major public health problem in the state. Any disease that causes one death out of every twenty-five deaths in Illinois is still a serious disease.

The control of tuberculosis will still be a serious problem as long as the undiagnosed and undiscovered case is allowed to be free in an uninfected population and until these cases are found there must be no let up in finding the cases and getting them under proper supervision and care. For this reason the search for early cases of tuberculosis must be made among persons who are apparently healthy and who do not present the symptoms of the disease. This can only be done through the use of the x-ray since the early case of tuberculosis and even moderately-advanced cases may show no outward signs of the disease.

The Department of Public Health through its service with the Mobile units has given excellent cooperation in detecting these unknown cases of tuberculosis. During 1947, 48 counties in Illinois received the service of these units and more than 270,000 persons were x-rayed. A preliminary study of these reports reveals that about 15 out of every 1,000 persons x-rayed showed some evidence of tuberculosis. We wish to bring to the attention of the doctors of Illinois, the service offered by the Division of Tuberculosis State Department of Public Health in offering the Mobile x-ray unit to any community where the County Medical Society requests it. The Department will not only make every effort to visit the community at the earliest possible time and x-ray the residents but is willing to make follow-up x-rays in cases where this is necessary and report findings to the family physician.

A number of tuberculosis programs have been given during the year by various County Medical Societies and papers have appeared in the Illinois Medical Journal as well as a number of papers devoted to tuberculosis in the various sections. Outstanding among the meetings was the annual tuberculosis meeting conducted by the Peoria Tuberculosis Sanatorium and Peoria City Medical Society held at the Peoria Munic-

ipal Sanatorium. There was a joint meeting in Springfield with the County Medical Society, Trudeau Society and American College of Chest Physicians participating. Another outstanding meeting was held on November 19th when the Chicago Medical Society devoted its meeting at the John B. Murphy auditorium to a symposium on tuberculosis. A complete resume was made of the tuberculosis problem including nonmedical treatment of tuberculosis, surgery and chemotherapy of tuberculosis, streptomycin, BCG immunization and other related subjects.

Streptomycin is being extensively used in the treatment of tuberculosis in homes, offices and institutions throughout the country and with good effects. This agent is finding a place in the scheme of therapy. However, it is probably being used when not definitely indicated so a word of warning in the use of the drug may be inserted in the report of this Committee. The drug fails in some cases and also causes a condition more hazardous to future control of infection than existed before its use. This hazard is a result of the resistance which tubercule bacilli often develop to streptomycin. After extensive use of the drug the conclusion must be reached that it is not yet the ideal drug for the therapy of tuberculosis, particularly pulmonary, and some modification of streptomycin or some other anti-biotic may become available that will be more effective with less hazard. This gives pharmaceutical laboratories adequate reason to attempt to find a more perfect drug; until this more perfect method of treating tuberculosis is brought forward, the Committee feels that extreme caution should be used in the use of streptomycin in tuberculosis and only after an extensive study of the patient, the indications and the complications that may be involved. It should not be given to patients unless the functional capacity of the kidneys is known to be normal. It should always be reckoned as an adjunct to the accepted measures of bed rest and collapse therapy, and never as a substitute for these. Since it is given to patients with active disease, it is highly desirable that the patient be in a sanatorium during treatment.

The finding of tuberculosis patients among those apparently healthy has caused a great deal of thought to be used in formulating a method of accelerating this program. In the past the program has been entirely on the basis of voluntary participation. On August 6th, the Governor of Alabama signed into law an act which is a distinct departure from the voluntary approach to case-finding. This act requires that all residents of the state between the ages of 13 and 50 submit to an examination for tuberculosis. Furthermore, the law enforces fines for noncompliance. As an example of health regulation, this statute must be viewed with more than casual interest for this is the first time in the history of the United States that mass case-finding has been placed under the force of state law. It may be well for the citizens of the State of Illinois backed up by the Medical Society to consider placing case-finding on such a statewide legal compliance basis. Since tuberculosis is a contagious disease and must be subject to contagious disease control perhaps such a step may be wise in carrying on future tuberculosis case-finding programs. The public interest renders entirely defensible the use of legal compulsion.

An ultimate solution of the tuberculosis problem from case-finding to isolation must still be in the hands of the family physician who is the keystone in the arch of tuberculosis control.

1947 marks the 100th anniversary of the birth of Carlo Forlanini, originator of the systematic use of artificial pneumothorax as an adequate therapeutic measure for the treatment of pulmonary tuberculosis. The contribution that Dr. Forlanini made to the tuberculosis control programs by shortening the time of treatment and lessening the infection period of open cases makes it evident that some tribute should be paid to a pioneer of his forethought and skill. A purview of the modern management of pulmonary tuberculosis leads us to say that the universal acceptance of artificial pneumothorax in the treatment of pulmonary tuberculosis as practiced in this country is the greatest monument the medical profession has ever erected honoring the genius, Carlo Forlanini.

Many times in past history of tuberculosis control it was thought that the problem of prevention would be found in the immunization of large groups of susceptible individuals by artificial means but many of these agents together with the great minds that produced these have overlooked the fundamental fact that an attack of the disease does not result in immunization in either men or animals. At the present moment in this country BCG is going precisely through the same stages as all the others have gone. We find the same premises for its use just as shady, the claims for it just the same, no better results have been reported for it than some of the others; in fact, it differs very little from other preparations that have failed. It seems more likely the few good results on BCG were apparent rather than real. No doubt immunization of large groups of susceptible individuals such as Mexicans and Indians may be desirable from a public health standpoint but in communities where adequate tuberculosis programs are carried on with active case-finding surveys and educational methods, BCG does not offer much in the way of tuberculosis control. It has the added disadvantge that where large groups are immunized by BCG, the tuberculin test becomes positive and, therefore, eliminates the possibility of making a diagnosis by the tuberculin test which is still the final test that we have to prove tuberculosis, outside of the positive sputum. When everyone would have a positive tuberculin test it would be impossible to differentiate a lesion in the chest resembling a tuberculosis from a true tuberculosis.

The American Medical Association has created a section on Diseases of the Chest, deeming the subject of enough importance to do so after finding enough men in the medical profession interested in this particular field of medicine. This Committee endorses the new section and strongly urges the members of the Illinois State Medical Society to take part in the meetings and their discussions.

This Committee feels that we as a State Medical Society must not relax in our vigor of the campaign to impress on the family physician that he is the first to see a case of tuberculosis, should be the first to make the diagnosis and, therefore, is the man who must assume the greater part of the responsibility for tuberculosis control. In control and treatment the family physician and all available agencies need each other. Complete cooperation is successful where all interested agencies accept responsibility for the program of control.

Respectfully submitted, Fred M. Meixner, M.D., *Chairman,* Frank J. Smejkal, M.D., Robert K. Campbell, M.D., *Committee on Tuberculosis.*

REPORT ON THE COMMITTEE ON CANCER CONTROL

To The Members of The House of Delegates:

Activities in the fight against cancer in Illinois have increased considerably during the past year. Under the leadership of Dr. John A. Rogers, Executive Director of the Illinois Division of the American Cancer Society, that organization has expanded its functions considerably.

The organization of the Cancer Society in Illinois has remained generally the same with representation on all of the various committees of members of the medical profession. Mr. Edward Foss Wilson, of the Wilson Packing Company, has been elected as Chairman of the Executive Committee. The various committees have had many meetings for the purpose of passing on the many project applications for financial assistance, to coordinate the lay and professional educational programs, and for various special projects.

There are now fifty well organized county units of the Illinois Division scattered throughout the state. The county unit of the Cancer Society functions under an executive committee, fifty per cent of which is composed of lay persons, and fifty per cent of physicians. It might be well to stress that the American Cancer Society does not own or operate any medical installations and that all local projects, such as information centers and assistance to cancer clinics, are only undertaken *following the approval of the local county medical society.*

The financial campaign in the Illinois Division in 1947 was more successful than in previous years. A total of over a half million dollars was contributed by the citizens of Illinois, and in accordance with national policy, 40% of the gross, or $204,644.74, was forwarded to the New York office of the Society. It will be recalled that it is the policy of the American Cancer Society that 25% of all funds collected shall be expended for cancer research projects. It is interesting to note that research grants by the National Office in New York, extended to men working in institutions within the State of Illinois, has actually slightly exceeded this quota.

The program of Professional Education has been continued. Five day symposia on cancer were held in November, 1947, in January and in March of 1948. These courses are co-sponsored by the Illinois State Medical Society, and were conducted at Northwestern University Medical School, the University of Illinois College of Medicine, Loyola University School of Medicine (Mercy Hospital), University of Chicago School of Medicine, and Michael Reese Hospital. Emphasis has been on early diagnosis and treatment, and a total of nearly two hundred physicians have attended these cancer refresher courses.

The Professional Educational Committee of the Cancer Society arranged a similar course for Chicago physicians which was held a day at a time at weekly intervals. Attendance at these programs averaged between forty and sixty.

Through the cooperation of the respective Councilors of the State Medical Society, the Cancer Society has also sponsored one day cancer symposia for the First, Second, Fifth, Eighth and Ninth Councilor Districts and for the Winnebago County Medical Society. The expenses of the speakers and an honorarium is provided by the Illinois Division as part of its program of Professional Education.

A very active Dental Committee has been appointed, of which Dr. Frederick W. Merrifield is chairman, for the purpose of extending cancer refresher courses to the dental profession. The first of these was held April 14 and 15 at the University of Illinois College of Dentistry and Cook County Hospital. In addition, the Cancer Society is sponsoring jointly with the University of Illinois College of Dentistry, a series of weekly evening meetings. A capacity audience of over two hundred has been assured and it has been necessary to turn down many other applications for attendance at this course. An interesting innovation has been the transmission of these weekly programs by long distance telephone to dental societies in Scranton, Pennsylvania, and New Iberia, Louisiana.

The program of Lay Education has been increased in extent. It is believed that at least five million people have become aware of the cancer problem in the State of Illinois through avrious media of education—radio, newspaper articles and talks before various groups. While it is necessary that the public be informed of many of the grim statistics relative to cancer, it has been the policy of the educational program of the Illinois Division to stress the need for coming to the physician early, and emphasize the hopeful outcome in early cases.

One year ago, the Illinois Division had one cancer information center, located in its Chicago office. Two additional information centers have been established—in the "Back of the Yards" area and on the South Side—in Chicago. In addition information centers have been established in Waukegan, Elgin, Aurora, Rockford, Rock Island, Moline, Peoria, Joliet, Bloomington, Springfield, Decatur, Danville, Quincy and Alton. These centers, as the name indicates, are not for the purpose of diagnosis and treatment but urge the seeking of medical advice and are responsible for the local programs of the Cancer Society.

Plans are already under way for an elaborate cancer exhibit for the public in the Museum of Science and Industry in Chicago. Plans have been developed at the Illustration Studios of the University of Illinois and it is expected that this exhibit will be open in April, 1949.

For the period of January 1, 1947, to January 1, 1948, 2,310 apparently well women were examined at the Women's and Children's Hospital. Of this group, 1,537 were referred to their own physicians for medical care, 114 had cancerous or pre-cancerous lesions, and 1,423 had other conditions requiring treatment.

Reports of findings were sent to physicians requesting them. A verbal evaluation of the findings was given to the examinee and those who claimed to have no family physician were referred to the office of the Chicago Medical Society for names of doctors in their vicinity, or given names of specialists from the panel submitted by the Chicago Medical Society. We wish to emphasize that no treatment is carried on in the Prevention Center. As stated above, when a pathologic lesion is found, the patient is referred to his family physician, or to the Chicago Medical Society if he has no physician.

From 1800 to 1900 telephone inquiries are received each month in the office of the Cancer Prevention Center. Those requesting appointments are advised to visit their own physicians if symptoms of any disease are present. Most of those examined at the Cancer Prevention Center either have no family physician, or did not have any reason for seeking medical advice, but wanted to know what type of an examination could be considered a "Cancer Prevention Examination." Most examinees have been referred by friends and relatives who appreciated the educational value derived. A leaflet bearing the following information is given to each examinee:

"You have just received a complete and careful physical examination, the results of which the examing physician has discussed with you. If further investigation has been advised, you are urged to follow instructions. If you have been found physically normal, you are urged to see your own doctor for re-examination six months from now. Cancer pays no attention to appointment schedules and may develop a few days or weeks after an examination has been made. Therefore, do NOT, because your examination has been negative, feel a false sense of security. Remember the danger signals and seek medical advice immediately should any of the following signals appear regardless of how recently you have been examined in the prevention clinic."

Additional Cancer Detection Centers have been opened at the Henrotin, Grant and Mercy Hospitals; the installation of these centers has been approved by the Chicago Medical Society. A plan is already under way to utilize the clerical and other personnel of the Cancer Prevention Center of Chicago, Inc., for the establishment of a central appointment bureau. This will help distribute the overwhelming number of requests for appointments. It is hoped that the activities of this central appointment bureau may be extended to include a central statistical department for the consolidation of statistical material on all detection centers.

Under the guidance of Dr. Howard Gowen, Chief, Division of Cancer Control, the program of the State Department of Public Health has increased in scope, particularly in the promotion and establishment of cancer diagnostic clinics downstate.

At the end of June, 1947, there were ten state-aided cancer diagnostic clinics, and this number has now been increased to nineteen. The new clinics were established in the following locations: Graham Hospital, Canton; St. Elizabeth Hospital, Danville; Sherman Hospital, Elgin; Little Company of Mary Hospital, Evergreen Park; Ryburn Memorial Hospital, Ottawa; Adams County Cancer Clinic, Quincy; Savanna City Hospital, Savanna; and McLean County Cancer Clinic, Bloomington; and the Victory Memorial Hospital, Waukegan. Establishment of these clinics is effected with the approval of the respective local medical societies.

Another activity sponsored by the State Department of Public Health, is the educational program being conducted primarily for public health personnel. This includes both public health physicians and nurses. Eleven health officers were sent to the cancer refresher course conducted in Chicago under the auspices of the American Cancer Society and the Illinois State Medical Society.

Three two-day institutes on cancer were conducted primarily for the public health nurses, although hospital nurses and nurses from other agencies were also invited to attend. All three institutes were held in March and the locations were Chicago, Bloomington and Carbondale. Approximately 250 nurses attended the three sessions.

During the past year the State Department of Public Health has contributed money for buying of equipment for various diagnostic cancer clinics throughout the state.

Respectfully submitted, Warren H. Cole, M.D., *Chairman,* Roswell T. Pettit, M.D., Thomas C. Galloway, M.D., Edwin F. Hirsch, M.D., *Harry Otten, M.D., Charles L. Leonard, M.D., *Committee on Cancer Control.*

REPORT OF COMMITTEE ON NUTRITION

To The Members of The House of Delegates:

The Public Conference on Nutrition was held on October 1, 1947, at the John B. Murphy Memorial Auditorium, Chicago, in cooperation with the Chicago Medical Society. Other cooperating organizations were the Institute of Medicine, Chicago; The Chicago Nutrition Association; the Friends of the Land, a national organization whose aim is to conserve the top soil of this nation; and the Illinois State Medical Society.

Three sessions were held on that one day beginning at 9:00 a.m., ending at noon, resuming at 1:00 p.m.

*Deceased.

and ending at 5:00 p.m.; the evening session was held at 7:30 p.m. closing about 10:00 p.m. A total of approximately 1,300 to 1,500 people attended these three sessions. The talks were pointed more toward the lay mind being informative more than scientific and this end was attained to a considerable degree.

The group feels that the title "Nutrition Conference" detracted some from the general public appeal in having too much of a scientific designation. The next conference conducted by the Chicago Medical Society will probably be a public meeting on food.

The speakers participating in this program were of national prominence, covering subjects on "Appetite and Hunger," A. C. Ivy, M.D., Vice-President, University of Illinois Professional Colleges and distinguished professor of physiology, Chicago; "The Food Industry and the Public," G. A. Slan, president of the Nutrition Foundation of New York City; "The World Food Situation: Yesterday and Tomorrow," Dr. F. G. Boudreau, director, Milbank Foundation and chairman of the Food and Nutrition Board of the National Research Council, Washington, D. C.; "The Soil and Nutrition," Jonathan Forman, M.D., editor, Ohio State Medical Journal, vice-president, Friends of the Land, Columbus, Ohio; "Food and the Aged," Dr. Clive McCay, professor of nutrition, Cornell University, Ithaca, N. Y.; "Diet and Climate," H. H. Mitchell, professor of nutrition, University of Illinois, Urbana, Illinois; "Diet and Cancer of the Liver," Dr. H. P. Rusch, director, McArdle Memorial Laboratory for Cancer Research, University of Wisconsin, Madison, Wisconsin; "The Citizen's Responsibility," was discussed by John P. O'Neil, M.D., Chicago, Chairman of the Chicago Medical Society Committee on Nutrition and a member of the Committee on Nutrition of the Illinois State Medical Society.

We believe that this is the first instance where organized medicine has actively promoted a program designed primarily for lay public interest rather than for professional interest.

All things considered, being the first attempt, we believe much has been accomplished particularly because of the fact that the radio stations in Chicago and the newspapers of Chicago gave it most extensive publicity.

The proceedings themselves were published by The Milk Foundation of Chicago in a ninety-two page booklet with the complete report of all papers including the Question and Answer Period and Round Table Discussions which were held.

Respectfully submitted, G. C. Otrich, M.D., *Chairman,* E. S. Hamilton, M.D., Harlan English, M.D., E. P. Coleman, M.D., John P. O'Neil, M.D., *Committee on Nutrition.*

REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

To The Members of The House of Delegates:

Since the report to the House of Delegates last year regarding the survey of rural areas and senior medical students the following actions have taken place. The Illinois Agricultural Association Board of Trustees were interviewed and were enthusiastic in their endorsement of the idea of a Farmers and Doctors Medical Student Loan Fund. The board agreed to match whatever funds the State Medical Society chose to use and appointed three men to the Loan Board. They were Mr. Floyd Morris of Buffalo, Illinois, K. T. Smith of Greenfield, Illinois, and Lyman Bunting of Ellery, Illinois. The Council of the State Medical Society then agreed to set up a fund of $100,000 on a 50-50 basis with the I.A.A. and appointed Drs. Ed Hamilton, Everett Coleman and Harlan English as the three men to represent the society on the board. Publicity was released which was widely used throughout the entire United States concerning the Illinois cooperation plan. The board has met and on the basis of physician-patient population ratio and the number of doctors over 60 in various counties, set up a priority list for 20 counties in the state in the greatest need of replacement of essentially rural physicians.

The requirements for applicants for this loan fund are:

1. Must be native born and reared boy in his home county.
2. Must have completed his pre-medical education.
3. Must come from one of the 20 priority counties.
4. Must be recommended to the Loan Board in writing by his local county Medical Society and local Farm Bureau as being a needy boy who couldn't become a doctor without getting a loan for his schooling.
5. Must pass the aptitude test of the University of Illinois or its equivalent in a Class A medical school.
6. Must furnish a $5,000 ten year term insurance on himself payable to the Loan Fund Board.
7. Must sign an agreement to practice after one or two year interneship in a town of 5,000 or less *in his home county* until the loan and interest are repaid.

Since announcement of the Illinois plan several inquiries have come in. They are being processed and about four students per year for the next five years will be approved. Inquiries have come from all over the United States and parts of Europe.

With the Educational Committee, the Rural Medical Service groups have released a brochure, "Doctors and Horses." 10,000 copies of this booklet have been asked for by various interested persons. It is in the process of being rewritten now to include the Loan Fund requirements.

Increasing publicity and education of the public as to their role in rural health and the establishment of increased and better facilities has resulted in the collection of much money for new hospital construction as well as the voting of tax levies in other areas. The establishment of hospital authorities in parts of the state is being done. Nearly all this activity is of local community origin but County Medical Societies can render the public and themselves a great service by taking an active interest in the establishment of Health Councils to assist in hospital fund raising, increasing health standards and recruiting of nurses and doctors.

If we in the profession fail to provide intelligent leadership, we must not complain if smooth talking, power selfish agents of the state or federal government take over that function. In health matters our warning to County Societies is, "Get the ball and call the plays," or both the public and the profession will lose the game.

Respectfully submitted, Harlan English, M.D., *Chairman,* G. C. Otrich, M.D., W. I. Lewis, M.D., Edgar C. Cook, M.D., J. C. Redington, M.D., *Committee on Rural Medical Service.*

REPORT OF THE COMMITTEE ON ETHICAL RELATIONS

To The Members of The House of Delegates:

Again it is the pleasure of this committee to report that its activities the past year have been limited. Few meetings of the entire committee have been necessary.

It is a pleasure to report that the long, drawn out trouble in the Edgar County Medical Society has been amicably settled within the County, and Dr. Churukian has been requested to rejoin the Edgar County Medical Society.

A problem has arisen in Macon County and we expect to report to the Council in the near future in regard thereto. It is to be hoped that this will be settled within the County in the near future. We cannot but feel that the lack of work referred to this committe is an excellent indication of the manner in which the Medical Profession is working together.

Respectfully submitted, E. S. Hamilton, M.D., *Chairman,* G. Henry Mundt, M.D., G. E. Johnson, M.D., *Committee on Ethical Relations.*

REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

To The Members of The House of Delegates:

The Constitution and By-Laws Committee has considered several items of business during the past year and earnestly recommends the following:

1. Article IV, Section 6, of the Constitution, Past Service Members. Page 4. "A member who has been in good standing but who has become disabled, may on recommendation of his component society be made a Past Service Member, and have all the rights and privileges of membership without the payment of dues to the component or state society."

Failure to clearly define the term "disabled" has caused some confusion. This class of membership was intended as a recognition to members who had become totally and permanently disabled through accident, illness or advanced age, and thus unable to carry on in the practice of medicine. It was not intended as a means of relief from the payment of dues for members temporarily disabled. In order to clarify the situation it is proposed to amend Article IV, Section 6 of the constitution by inserting the words "totally and permanently" before the word "disabled."

2. Chapter XI, Section 7, of the By-Laws (page 24) "A physician living on or near a county line may hold his membership in the county most convenient for him upon permission of the society in whose jurisdiction he resides." This has caused some difficulty for members in certain counties. The original By-Law extends the democratic privilege to a member to join the society of his choice as a matter of convenience, provided he gets permission of the society in whose jurisdiction he resides. This permission may be difficult to obtain and it may even be denied. Such denial may work undue hardship on certain members maintaining their principal office and having hospital connection in the county adjoining the county of residence, as many hospitals require local county society membership as a basis for staff appointments. Further, as a matter of convenience, a better attendance at society functions and meetings will probably result if the member can be privileged to join and become active in the society of his choice. The most reasonable solution seems to be the deletion of the portion of the sentence "upon permission of the Society in whose jurisdiction he resides."

3. Suggestions regarding an annual assessment of one or two dollars per member for the Benevolence Fund, deserve serious consideration and should be discussed by the House of Delegates.

Respectfully submitted, Warren W. Furey, M.D., *Chairman,* H. Noland Fisher, M.D., Pliny R. Blodgett, M.D., *Committee on Constitution and By-Laws.*

REPORT OF COMMITTEE ON MEDICAL HISTORY

To The Members of The House of Delegates:

On October 5, 1947, the Council created this committee to arrange for the compilation and publication of another volume on the History of Medical Practice in Illinois. This will complement and carry forward from 1850 the volume prepared by Dr. Lucius Zeuch and his committee in 1927.

The committee has held a number of meetings to survey the sources from which the material can be gotten. By the time the House of Delegates assembles it is hoped that we shall already have arranged to have this material collected and properly catalogued. The exact form in which this material shall be presented has not yet been determined, but it seems likely that each of a number of men will be asked to write a chapter on some phase of the subject in which he has a special interest. This is presented simply as a progress report.

Respectfully submitted, James H. Hutton, M.D., *Chairman,* Harold M. Camp, M.D., Charles P. Blair, M.D., E. H. Weld, M.D., D. D. Monroe, M.D., David J. Davis, M.D., J. J. Moore, M.D., George H. Coleman, M.D., *Committee on Medical History.*

REPORT OF THE ADVISORY COMMITTEE TO THE VETERANS ADMINISTRATION

To The Members of The House of Delegates:

Members of this Committee have had several meetings with representatives of the Veterans' Administra-

tion as well as conferences with the Chief Medical Officer of this region.

It is the desire of the Veterans' Administration to have the Iilinois State Medical Society sign a new agreement which will continue in force for one year from July 1 each year. The Council of the Society has approved the new agreement, which will go into effect next July 1. Fee tables will be subject to revision at the end of each fiscal year, depending on the appropriation made by Congress for the Veterans' Administration as well as on other circumstances.

A new fee table which has been submitted represents the maximum that may be paid in any State. The Veterans' Administration realizes that to suggest the adoption of a nation-wide schedule would be unfair and impractical because of the variations that exist geographically throughout the nation. For example, some of the maximum fees allowed in this format may be in excess of the fees charged private patients in certain localities in the State. If a physician makes a misstatement in rendering a bill that it is not more than the usual fee charged by him for that particular or specific service, the government may step in and take action. It is to avoid any such possibility that this new fee table has been worked out.

Members of this Committee attended the conference on the Veterans' Administration Home-Town Medical Care Program sponsored by the Council on Medical Service of the American Medical Association in Chicago on November 6, 1947. The meeting was held as a result of action taken by the House of Delegates of the American Medical Association at Atlantic City in June, 1947. At this conference, General Hawley, who was then Chief Medical Director of the Veterans' Administration, agreed to meet with representatives of the Council on Medical Service of the American Medical Association to discuss further the policies and program of the Veterans' Administration pertaining to the Home-Town Medical Care project.

At present about 4,300 physicians in Illinois are participating in the program of examination and treatment of veterans for service-connected disabilities. Since the inception of this program in June, 1946, only three physicians have been dropped from the rolls for cause in this regional area. None of these involved overcharging, contrary to the front page headlines in the daily press in January, 1948, in which intemperate and poorly chosen language was used in the reported interviews given out by the new Medical Director of the Veterans' Administration. A letter was promptly sent to the Director protesting the language of this interview and presenting the facts regarding the sincere and honest participation of Illinois physicians in this program. This was answered by the Director with the implied statement that he had been misquoted. Perusal of a copy of his interview which was furnished the Secretary of the Illinois State Medical Society causes the Committee to feel that his statements were in poor taste and lacked the dignity and judgment to be expected from one of his position.

Of the physicians now on duty, a vast majority are rendering entirely satisfactory service and their charges are in accordance with the contract between the Veterans' Administration and the Illinois State Medical Society. Only about one out of 400 examination reports now has to be returned for further information or correction. Since September, 1946, through December 31, 1947, about 32,000 treatments and about 40,000 examinations have been given by Illinois physicians who were paid about $473,000, with about another $30,000 in fees still due. A period of about five weeks now elapses from the time the physician mails his bill until he receives his check.

The Illinois phase of the Home-Town Medical Care Plan has been quite successful due to the wholehearted cooperation and clear thinking on the part of Dr. B. A. Cockrell, Chief Medical Officer of this regional area, and to the activities of the Secretary of the Illinois State Medical Society.

In contrast to the employment of a considerable clerical force by many State Medical Societies, Illinois has thus far been able to participate quite fully in this program with little expense to the State Society and has incurred to the knowledge of the Committee but a minimum of criticism from either veteran or physician.

Respectfully submitted,

Percy E. Hopkins, M. D., *Chairman,* Irving H. Neece, M.D., Walter Stevenson, M. D., Everett P. Coleman, M. D., Harold M. Camp, M. D., *Advisory Committee to the Veterans' Administration.*

DR. HOPKINS: Because of the time of publication of the reports in the Handbook, the figures were not available; therefore this supplementary report is presented.

The new contract submitted by the Veterans' Administration for the care of veterans with service-connected disabilities by members of the Illinois State Medical Society is now being studied by the legal counsel of the Illinois State Medical Society. This contract has not yet been signed by the officers of the Society and when and if it is approved, will be effective for one year from July 1, 1948, to June 30, 1949.

From April 1, 1947, through March 31, 1948, 26,708 examinations were made on 17,885 individual veterans by participating doctors and 25,575 treatments were rendered to 9,982 veterans. The Veterans' Administration has paid a total of $403,327.34 to physicians of Illinois for this care. In addition the doctors of Illinois through various hospitals for the treatment of veterans hospitalized, exclusive of state institutions, covering 41,324 days of hospital treatment.

There are at this date about 4,200 doctors in Illinois participating in the care of veterans with service-connected disabilities.

The opinion of the Committee remains unchanged regarding the designation of this program as one of Home-Town Medical Care because such a designation is incorrect.

Respectfully submitted,

Percy E. Hopkins, *Chairman,* Irving H. Neece, Walter Stevenson, Everett P. Coleman, Harold M. Camp.

REPORT OF COMMITTEE ON CRIPPLED CHILDREN'S CLINICS

To The Members Of The House Of Delegates:

Crippled Children's Clinics in Illinois are well organized throughout the state. They are conducted by several agencies. The principal ones being:

1. Illinois Elks Association Crippled Children's Commission.

2. Division for Crippled Children under the supervision of Dr. Herbert Kobes, of the State Department of Health.

3. A number of independent Crippled Children's Clinics, sponsored by individual County Medical Societies.

In Chicago there are twelve principal children's clinics all of which are connected with Medical Schools or large hospitals.

Throughout the state the Clinics are as follows:

Elks Association
- Clinics held during the past year 150
- Total examinations 2,073
- Number of cases hospitalized 148
- Number of hospitals used 12

Division for Crippled Children Department of Public Welfare:
- Clinics held during the past year 141
- Cities in which clinics were held 35

Under the Independent Clinics throughout the state a number of County Medical Societies have sponsored their own crippled children's clinics, each with the supervision of an experienced orthopedic surgeon. The number of these is not available.

Chicago Clinics

In Chicago twelve principal crippled children's clinics are active. They are as follows:

University of Illinois. Out patient Orthopedic Dept.:
- Clinics held per week 10
- Patients treated during past year 7,667
- Of this number the majority were children.

Loyola Medical School. Clinics held at Mercy Hospital Dispensary:
- Clinics held per week 1
- Patients treated during past year 623

Northwestern U. Medical School. Montgomery-Ward Clinic:
- Clinics held per week 4
- The number of cases treated is not available.

Chicago Medical School. In connection with Mt. Sinai Hospital:
- Clinics held per week 4
- Outpatients for year of 1947 1,200
- A large number of which were children.
- Hospital patients 30

University of Chicago:
- This is a pay clinic. Statistics not available.

St. Luke's Hospital:
- Clinics held per week 4
- Approximate number of patients per week 35

Michael Reese Hospital. Mandel Clinic:
- Clinics held per week 1
- Patients treated 224

Presbyterian Hospital. Central Free Dispensary:
- Clinics held per week 4
- Average of patients per clinic 34

Provident Hospital:
- Clinics held per month 10
- Average of patients per clinic 75
- most of which are poliomyelitis cases.

Shriners Hospital:
- Clinics held per week 2
- Average of patients per week 150

Childrens Memorial Hospital:
- Clinics. Forty-eight clinical sessions were held during the year.
- Patients treated during 1947 438

Cook County Hospital:
- Six orthopedic clinics are held each week. The average number of patients seen at these clinics is 45. 30 per cent of these are children.

In the City of Chicago the number of children's clinics and the hospitalization facilities are adequate to give proper treatment to the present number of crippled children, both in the acute and in the chronic stages.

Downstate clinics are held usually three or four times a year in each of the centers. Throughout the state clinics are held in most of the counties. The location of these are such that almost all of the crippled children can be brought to the clinics regularly.

Respectfully submitted,

Frank G. Murphy, M. D., *Chairman,* Ralph P. Peairs, M.D., Charles Papik, M.D., Herbert Richard Kobes, M.D., *Committee on Crippled Children's Clinics.*

REPORT OF THE COMMITTEE ON VENEREAL DISEASE CONTROL

To The Members Of The House Of Delegates:

The advisory function of the Committee on Venereal Disease Control has not been excercised very extensively during the past year, due to the fact that Dr. Leonard Schuman, Chief of the Division of Venereal Disease Control, State Department of Public Health, has proven to the committee his ability to cope with the problems in a very efficient manner. Highlights of the program for 1947 which he has followed and contemplated plans for the ensuing year become a part of this report.

This report presents two tables. One dealing with morbidity reporting for the calendar year 1947 as compared with the corresponding period of 1946 and two, a table of Rapid Treatment facility admissions for the year 1947 as compared with 1946.

It is gratifying to note, first, that of all the cases admitted to the Rapid Treatment Centers, more than 60% were referred by private physicians. Second, that the higher percentage of reporting of early infections and potentially infectious syphilis is being maintained as in the preceeding years though there has been a decline in such early case reporting by private physicians.

For the fiscal year 1947, 527 treatments given by private physicians were at state expense. This was for

TABLE I. — REPORTING OF VENEREAL DISEASES BY ALL SOURCES AND BY PRIVATE PHYSICIANS

ILLINOIS — CALENDAR YEARS 1946-1947

DISEASE AND STAGE	NUMBER OF CASES REPORTED			
	TOTAL SYPHILIS		PRIVATE PHYSICIANS	
	1946	1947	1946	1947
SYPHILIS	23,701	19,360	11,084	8,622
Primary and Secondary	6,656	5,195	2,493	1,768
Early Latent	6,985	5,863	3,153	2,200
Late and Late Latent	9,442	7,753	5,186	4,466
Congenital	618	549	252	188
GONORRHEA	37,956	36,794	7,389	5,947
CHANCROID	969	421	43	30
LYMPHOGRANULOMA VENEREUM	210	226	7	3
GRANULOMA INGUINALE	65	57	5	5

patients who live in areas inaccessible to clinics where they would have received indigent care.

Contact investigations by the Illinois Department of Public Health has shown improvement for this period over the preceeding year. Improvement has been noted in the percentage of contacts examined, those found infected, and those placed under treatment. This same type of service for private physicians has also shown a corresponding improvement.

In the field of educational activities, professional education has also been augmented. One private physician serving as a Clinic Director was sent to Hot Springs Medical Center for postgraduate education in venereal disease. A health officer also was registered for the course.

The coordination of all policies and procedures dealing with venereal disease control in the form of manuals was initiated this past year by the preparation of a manual for the Rapid Treatment program. It is contemplated to project this same activity among other segments of the venereal disease control program.

The distribution of drugs to private physicians has increased remarkably. In general, there was more than 100% increase in penicillin distribution in the fiscal year 1947. This is accounted for not only by the increase of case referrals for Rapid Treatment but also by the greater utilization of penicillin schedules by private physicians for their private cases.

For the next fiscal year, in addition to increase stimulation of the Rapid Treatment program, it is planned to place emphasis on professional education. For private physicians this will be in the form of a monthly professional bulletin dealing with problems as have been encountered, through letters from private physicians. The form of this bulletin will be similar to that employed by the Illinois Cancer Society and should be of value to the private practitioner. Furthermore, it is hoped that more physicians will take advantage of the offer to gain additional postgraduate instructions in venereal disease by attending Rapid Treatment Centers in Chicago and St. Louis, at state expense for a course of instructions.

Dr. Schuman is to be highly commended for his thorough, efficient handling of the V. D. problem in the state of Illinois; for his forward looking program for the future, for his desire to enlist the full cooperation of the entire membership of the medical profession of this state and to provide additional training at state expense for those desiring same.

Respectfully submitted,

I. H. Neece, M. D.
Chairman, Advisory Committee on Venereal Disease Control.

In Table I a comparison of venereal disease reporting for 1946 and 1947 by all reporting sources and private physicians has been made.

56,858 cases of venereal disease were reported to the Illinois Department of Public Health in 1947 as compared to 62,901 in 1946, a decrease of 10 per cent. Significant decreases in 1947 were apparent for syphilis (19%) and chancroid (57%) case reporting. The reporting of gonorrhea, lymphogranuloma and granuloma inguinale varied slightly for the two years compared.

Although the decrease in syphilis reporting has been fairly evenly distributed among all its stages, the high percentage of early syphilis reporting apparent in 1946 has been maintained in 1947. Gonorrhea in 1947 with 36,794 cases, presented a very slight decrease to the 1946 total, the highest reporting level in its history in Illinois.

Of the total number of venereal disease cases reported, private physicians in 1947 reported 14,607 or 26

TABLE II. — DOWNSTATE ILLINOIS CASES ADMITTED TO RAPID TREATMENT FACILITIES FOR THE CALENDAR YEARS 1946-1947

Rapid Treatment Facilities	*Period*	*Total Admissions*	*Syphilis*					*GONORRHEA*	*OTHER VENEREAL DISEASES*
			Primary and Secondary	*Early Latent*	*Late and Latent*	*Congenital*	*Central Nervous System*		
Downstate Illinois Hospital Facilities	Jan. to Dec. 1946	664	622	27	5	10	——	——	——
	Jan. to Dec. 1947	840	549	238	15	36	2	——	——
Downstate Illinois Special P.O.B. Study	Jan. to Dec. 1946	——	——	——	——	——	——	——	——
	Jan. to Dec. 1947	93	57	20	15	1	——	——	——
Chicago Intensive Treatment Center	Jan. to Dec. 1946	312	149	87	9	5	33	15	14
	Jan. to Dec. 1947	267	116	82	16	11	26	14	2
St. Louis Midwestern Medical Center	Jan. to Dec. 1946	358	240	79	10	9	13	3	4
	Jan. to Dec. 1947	404	218	103	8	15	44	13	3
All Hospital Facilities	Jan. to Dec. 1946	1334	1011	193	24	24	46	18	18
	Jan. to Dec. 1947	1604	940	443	54	63	72	27	6

per cent, as compared to 18, 528 or 30 per cent in 1946. The over-all decrease in reporting of venereal disease by private physicians in 1947 as compared to 1946 was 21 per cent. However, the most significant percentage decreases were found for syphilis (22%) and gonorrhea (20%). In 1946 over one-half (51%) of all syphilis cases reported by private physicians were infectious or potentially infectious, however, in 1947 this percentage decreased to 46 per cent, indicating a slight diminution in early syphilis case finding.

The rapid treatment program of the Illinois Department of Public Health, utilizing private hospital facilities on a per diem basis, continued to show increasing popularity in 1947. Besides agreements with 23 private hospitals in downstate Illinois, downstate patients have access to the two rapid treatment centers in Chicago and St. Louis respectively. A specialized study using POB was developed in 1947 in three large health department centers. Private physicians and venereal disease clinics may refer cases of early syphilis, congenital syphilis and syphilitic pregnancies to these institutions for rapid treatment at state expense.

Table II presents a comparison between the years 1946 and 1947 of the numbers of downstate Illinois cases admitted to rapid treatment facilities. Total admissions in these facilities increased 20 per cent in 1947 over the admissions in 1946. The greatest admission increase was in the Downstate Illinois Hospital Facilities where 840 cases were admitted in 1947 as compared to 664 in 1946, an increase of 20 per cent. A small percentage (13%) increase of the total admissions were made to the St. Louis Midwestern Medical Center. The Chicago Intensive Treatment Center, however, admitted less cases in 1947 than in 1946, a decrease of 14 per cent.

It is significant that in 1947 a greater number of infectious and potentially infectious cases of syphilis were admitted to all hospital facilities. The inclusion of early latent cases in the rapid treatment program was mainly responsible for this increase.

REPORT OF THE WOMAN'S AUXILIARY

To The Members Of The House Of Delegates:

As president of the Woman's Auxiliary to the Illinois State Medical Society, I wish to submit the following report:

1. Meetings.

In all, three meetings of the Board of Directors of the Woman's Auxiliary to the Illinois State Medical Society have been held during the year. These include the post-convention and two regular board meetings held in Chicago in November and March. Plans for the annual convention, to be held at the Congress Hotel, in Chicago on May 10 and 11, call for a pre-convention and a post-convention board meeting.

The first annual conference for County Presidents and Presidents-Elect was held during the November board meeting, at which time the outline for the year's work was discussed by both State Officers and County Presidents.

2. Officers.

The Officers for the year have fully cooperated with the president in trying to carry out the work of the Auxiliary as outlined by the Medical Society.

3. Organization.

Organization has been our main objective during the year; a goal was set for 1,200 members. To date our membership is 1,269, a gain of 206 new members. There have been no new counties organized, although the organization chairman has continued to contact all counties. Several counties have shown interest in the organization and our hope is that they may be organized in the near future.

The Auxiliary wishes to thank the Councilors of the State Society and Presidents of the county medical societies for their cooperation in organization work.

The Auxiliary now has twenty county organizations and members at large in thirteen counties, making representation in thirty-three (33) counties.

4. Benevolence.

The Auxiliary is proud to announce that the treasurer has sent a check for two thousand forty-three dollars and fifty-two cents ($2,043.52) to the Benevolence Fund to date. This is five hundred forty-eight dollars and eighteen cents ($548.18) more than was donated at this time last year. There will be additional contributions before the close of the year in May. It is hoped that the twenty-five hundred mark may be reached.

5. Public Relations.

The advice of the Advisory Committee of the Illinois State Medical Society was followed in the developing and maintaining of liaison contacts with other organizations. Public Relations Programs were held in most counties with speakers on Pre-payment Medical Care, Cancer, Tuberculosis, and many other health subjects. These meetings have been well attended and show interest in health education by the public.

6. Legislation.

The Legislative Chairman has kept in close touch with all counties, and has mailed out all information received from the National Chairman of Legislation. Bulletins from the National Physicians Committee for the Extension of Medical Service, also were sent out to all Committee Chairmen of the Auxiliary. It is encouraging to find that the members of the Auxiliary are becoming better informed on medical legislative problems, both state and national.

7. Hygeia.

Hygeia, the authentic health magazine, has been placed in schools, libraries, hospitals and various public reading places by the Auxiliary to stimulate health education.

There was one school of instruction held during the year, presided over by the directors, at which time officers and chairmen were instructed in the duties of their offices, and ideals and purposes of the organization.

8. President.

As President I have attended when able the meetings of Cook County Auxiliary and my own branch, when I was not out of the city on Auxiliary business. The

following branches of Cook County have been visited, Aux Plaines, Calumet and North Shore. The counties down state that were visited are, Adams, Marion-Clinton, Kane, St. Clair, Sangamon, Peoria, Knox, Henry, Will-Grundy and Rock Island.

Invitations have been accepted to visit Bureau, Vermilion and Logan Counties before the close of the year in May.

The annual convention of the Woman's Auxiliary to the American Medical Association held in Atlantic City, New Jersey, in June 1947 was attended, as well as the fourth annual Conference of State Presidents and State Presidents-Elect, held by the Auxiliary to the American Medical Association in Chicago in November 1947. This conference is held for the purpose of exchanging ideas and discussing problems that arise in various states. It enhances a friendly and cooperative spirit between the members.

On advice of the Council of the State Society the president attended the Illinois State Wide Public Health Committee meeting held in Chicago in September 1947.

Material pertaining to "Questions Answered about an Auxiliary" was compiled and mailed to all State Auxiliary officers, Chairmen, members at large and County Presidents, and also to the Officers and Councilors of the Illinois State Medical Society.

Instructions, pertaining to the duties of their offices, were given to all state chairmen at the beginning of the year and a close personal contact has been maintained at all times. County Presidents and County Presimight become better acquainted, not only with the work dents-Elect were invited to meetings so that they of the State Auxiliary, but with the state officers.

The encouragement and cooperation of the Advisory Committee of the Illinois State Medical Society has meant much to the progress of the Auxiliary. This committee is composed of Dr. Darwin B. Pond, Chairman, Dr. Harold M. Camp, Dr. Rollo K. Packard, and Dr. E. G. Beatty.

The Auxiliary wishes to say as always that no task is too great to assume that may be assigned by the Medical Society. It stands ready at all times to be of assistance.

Respectfully submitted,

Mrs. John Soukup, *President, Woman's Auxiliary to The Illinois State Medical Society.*

THE PRESIDENT: There is no unfinished business, so we will take up the introduction of resolutions and the referral of same to the Committee on Resolutions.

DR. LEO O. FRECH, Decatur: I wish to present the following resolution from Macon County Medical Society, adopted at its meeting May 7, 1948.

1. *Medical Benevolence*

Whereas, The Illinois State Medical Society has seen fit to establish a program of benevolence for the benefit of unfortunate members or their dependents, and

Whereas, a committee on medical benevolence has been elected by this House of Delegates to administer said program, and

Whereas, it is necessary to provide ample funds to fully carry on an ever-increasing loss of benevolence, and

Whereas, said program has been, and is now, administered on a voluntary income basis and subscriptions to which fund have been, and in the future will probably be, inadequate particularly so in times of economic depression, therefore

Be it Resolved, that a yearly per capita tax of $2.50 be levied on all members of each and every component county medical society, and that said $2.50 be collected as part of the annual state and county dues; earmarked for and paid into the state benevolence fund to be used by the committee for economic relief of distressed members or their dependents, and

Be it Resolved, that any and all voluntary contributions, whether from the Council of this medical society, organizations or individuals be accumulated to set up a trust fund, or endowment, the income from which to be used when, and if, necessary to augment the yearly income from assessments, and

Be it Resolved, that when, and if, such endowment, or fund, becomes sufficiently large to furnish ample income to carry the program, that yearly assessments then be discontinued, and

Be it Resolved, that any existing yearly surplus from assessments be transferred to the endowment or trust fund, and

Be it Further Resolved, that this program be established at such a time and in such a manner that assessments will accrue to the benefit of the program with the payment of the 1949 yearly State Medical Society dues.

DR. C. PAUL WHITE, Kewanee: Henry County likewise feels very much like Macon and this resolution came after there had been an appeal made to Henry County for contributions to the Benevolence Fund. We do not believe that the milk of human kindness is so sour in the breasts of ninety per cent of the members that would not give at least five dollars to help a worthy cause of this kind. It did come out that there should be some other term, something like security fund, so as to remove some of the stigma of being helped or being the object of charity on the part of other practitioners; therefore this resolution was

2. *The Benevolence Fund*

Whereas, the Benevolence Fund of the Illinois State Society based, as it is, on voluntary contributions of Society members and appropriations by the Council from the General Fund is wholly inadequate to properly administer relief to needy members, their widows, widowers, or their children, and

Whereas, the Benevolence Fund is a demonstration of a professional interest and brotherly love for unfortunate physicians,

Therefore, we, the Henry County Medical Society, petition the House of Delegates of the Illinois State Medical Society to enact the following resolution, namely:

"Each Society of the Illinois State Medical Society shall assess $5.00 for each member, this amount to be over and above the regular dues payable to the Illinois State Medical Society and this amount earmarked to the Benevolence Fund of the Illinois State Medical Society."

This paragraph shall be the second paragraph of Section Six of Article Six of the Constitution of the Society.

DR. WHITE: You understand, gentlemen, that would give some $45,000 to $50,000 per year which would make it possible to take it out of the merely relief of $30 a month and give the recipient and dependent sufficient to keep them off the bread line.

DR. DAVID FEY, Peoria: Peoria County presents this resolution which was unanimously passed on May 4, 1948.

3. *Non-partisan Administration of the Illinois State Hospitals*

Whereas, over 40,000 Illinois citizens are at present patients in the Illinois State Hospitals and,

Whereas, they are entitled to adequate medical care, and

Whereas, inadequate medical care results from "spoils politics" interference, therefore

Be it Resolved, that the Peoria Medical Society go on record as favoring non-partisan administration of the Illinois State Hospitals and instructing its delegates to the Illinois State Medical Society meeting to introduce and seek the acceptance of a resolution at the State meeting favoring such non-partisan adminstration.

4. *Establishment of a Two-year Training Course for Bedside Nurses*

DR. E. H. OCHSNER, Chicago: I would like to have your attention for just exactly two minutes. Two major problems that are today facing medicine are the shortage of trained nurses and hospital facilities. I have a suggestion that I believe would in part at least alleviate these shortages. My suggestion is the following:

Establish a two-year training course specifically for bedside nurses in addition to the three year course now in operation.

Make the following requirements for such a course:

A. Certified hospitals.

B. Admission Requirements

1. Two years high school.
2. Two years practical experience in some useful occupation.
3. Two years nursing training in bedside nursing.

When such a course is satisfactorily completed the applicant is to be awarded the degree B.S.N.

I move that this be referred to the Committee on Medical Education and Hospitals with the request that, if possible, they report on the matter at the meeting of the House of Delegates on Wednesday.

(Motion seconded by Dr. J. W. Long, Robinson).

DR. E. S. HAMILTON, Kankakee: This cannot be referred to a Committee; it must be referred to a Reference Committee. (Motion carried).

THE SECRETARY: It will be referred to the Committee on Miscellaneous Business, of which Dr. A. J. Linowiecki is the chairman.

Dr. W. O. THOMPSON, Chicago: Mr. Chairman and members of the House of Delegates: The Committee on Medical Education and Hospitals would like to present a resolution on the general practitioner. In making this resolution we feel it is very important to approach this problem from a common sense point of view and to try and pick this out from what we already have and go on from there.

5. *Advancement of the General Practitioner*

Whereas, the general physician is the backbone of medical practice, and

Whereas, the general practice of medicine often represents good preliminary training for a specialty, and

Whereas, the development of the various Specialty Boards, although representing a definite forward step in medicine, has tended to result in the relegation of the general physician to an inferior status, and

Whereas, the shortage of hospital beds has been so great that the general physician has had difficulty in securing staff appointments and in getting his patients into the hospital, and

Whereas, the medical school curriculum places too much emphasis on specialties and is in need of critical review, and

Whereas, the present method of selection of medical students, which is based largely on academic record, is the subject of much controversy, and results in the elimination of many candidates who would make outstanding physicians,

Therefore Be it Resolved, that the House of Delegates of the Illinois State Medical Society request the Medical Schools of the State of Illinois:

1. To review critically their method of selection of medical students so that academic record will not be the only factor in determining admission to the medical school, and good average students who have qualities which indicate that they will make good physicians be given an opportunity to study medicine.
2. To review their curricula and methods of teaching critically with the idea of providing in the medical course a broad base of training for most students which will insure a good groundwork for general practice and any of the specialties.
3. To devise and sponsor internships and residencies which will provide the general physician with the type of training which he needs to prepare himself for the general practice of medicine, and

Be It Further Resolved, that the various Specialty Boards approved by the American Medical Association be asked to revise their standards so that general physicians desiring to enter a specialty may be given credit for their work in general practice, and

Be It Further Resolved, that the general hospitals of the state, wherever it is practical to do so, be requested to set up departments of general prac-

tice with representation on the executive committee of the staff, and

Be It Further Resolved, that we instruct our delegates to the American Medical Association to present this resolution to the House of Delegates of the American Medical Association with the idea of having its principles adopted throughout the country.

DR. WARREN FUREY, Chicago: I have no resolution to offer but according to the by-laws any changes in the constitution and by-laws must be introduced at this meeting to be considered at the final meeting of the House. The report of the Constitution and By-Laws Committee is given on Page 60 of the Handbook and their recommendations are as follows:

Article IV, Section 6 of the Constitution, *Past Service Members.* Page 4. "A member who has been in good standing but who has become disabled, may on recommendation of his component society be made a Past Service Member, and have all the rights and privileges of membership without the payment of dues to the component or state society."

The Committee recommends the amendment of this Section by inserting the words *"totally and permanently"* before the word "disabled".

Chapter XI, Section 7, of the By-Laws (page 24): "A physician living on or near a county line may hold his membership in the county most convenient for him upon permission of the society in whose jurisdiction he resides."

The Committee recommends the deletion of the portion of the sentence "upon permission of the Society in whose jurisdiction he resides".

My understanding is that the difficulty which led to the proposal to change this by-law has been peacefully adjudicated.

The Committee felt that an annual assessment of one or two dollars per member for the Benevolence Fund deserves serious consideration. Under the resolution presented by Dr. White, if it is passed, amendment of the constitution will be required. We would recommend that instead of stating five dollars in the constitution and by-laws, it would be stated, that these funds, or words to that effect. If the constitution is amended it will be necessary to amend also Chapter IX, Section 7 of the By-Laws.

THE PRESIDENT: This matter will be referred to Committee "B". I would now ask each Reference Committee chairman to come forward and receive the names of his Committee and announce the place of meeting.

There being no further business, on motion of Dr. H. K. Scatliff, Chicago, seconded by Dr. A. M. Vaughn, Chicago, the House adjourned at 4:35 P.M., to reconvene on Wednesday morning at 9 A.M.

MEDICAL ALUMNI ASSOCIATION UNIVERSITY OF ILLINOIS

Dr. Michael H. Streicher was installed as president of the Medical Alumni Association of the University of Illinois at the organization's annual luncheon May 11 at the Palmer House.

Dr. Streicher is an associate professor of medicine at the University of Illinois.

Dr. Frank Lee Stone was selected as president-elect. Other officers elected to serve one-year terms were Dr. Edward A. Christofferson, first vice-president; Dr. Walter J. R. Camp, second vice-president; and Dr. Walter Simmonds, necrologist.

DR. J. ROSCOE MILLER INSTALLED AS CHICAGO SOCIETY PRESIDENT

Dr. J. Roscoe Miller, dean of the Northwestern University medical school, was installed as president of the Chicago Medical Society at a dinner at 7:30 p.m. Wednesday, June 16, in the Gold Coast Room of the Drake Hotel. He succeeded Warren W. Furey. A fellowship hour at 6:30 p.m. preceded the affair, at which Dr. Willard O. Thompson, of the University of Illinois medical faculty, was named president-elect and chairman of the council.

The Society, numbering more then 6,000 members, is one of the largest individual medical organizations in the United States.

INDUSTRIAL HEALTH



Light Work*

Frederick W. Slobe, M. D.
Chicago

The term, *light work* as commonly used in designating the disposition of the industrially disabled might well be abandoned to a large degree. It is ambiguous and relative; consequently, its use leads to confusion and misinterpretation. In any given instance, the physician, employee, employer, or insurance company may construe its meaning quite differently.

**This editorial from Industrial Medicine (May 1948) deserves the earnest attention of all physicians who have occasion to write certificates recommending conditional employment for convalescent patients. For practicability it is suggested that the physician ask the worker to explain the nature of his regular employment and with this knowledge the doctor should specify in descriptive terms the type of industrial activity that should be avoided over a given period of time.*

For example: "For three months avoid lifting, pulling, pushing in excess of 30 lbs." — "Avoid work on ladders, scaffolds, high places until further notice"— "Sedentary employment, where he will be sitting down 50% of the working hours". J. H. C.

The modern and all important *fourth* phase of treatment—namely, rehabilitation and return of the employee to productiveness—is conditioned upon an early return to functional activity and the best site for such activity is the employee's place of employment. All treatment, from its very inception, is directed toward that goal. And the sooner it is done, the better; the longer it is delayed, the more likely the development of an unfavorable attitude, neurosis, or compensation complex and that retardation of recovery which is always concurrent with lack of physical and mental activity.

The convalescing employee, then should be sent to *work*. Through close cooperation between the physician, employer, and employee, there should be a definite understanding as to the nature of the work to be performed. That work is selected which is optimal for the employee in his existing state and its specifications should be changed as his condition improves. The work selected should utilize whichever capabilities exist. This may mean modifying or changing the job, that is, fitting the job to the man. Wherever possible, the employee should have demonstrated to his

own satisfaction that he can do such tasks as he will be expected to perform by engaging in similar activity during treatment; the employer, likewise, should appreciate that his full cooperation is essential. It is obvious that this concept of returning to specified, supervised work is quite different from the ambiguous term, *light work*.

Several barriers to the successful development of such a program are frequently encountered. Some employers are loathe to cooperate. They may grumble about supervising such *special* work or state that they prefer that the employee remain at home until he is fully able to do his regular work. It requires education to convince some employers that such an attitude increases compensation payments in the aggregate, together with the other attendent costs of increased absenteeism, and the higher awards at the more intangible factors related to morale, the industrial commission, without considering employee relationship, and productivity.

Some labor unions, likewise, constitute a barrier because of strict instances on wage differentials, seniority rights, and refusal to accept changes in job classification. By strict adherence to such inelastic rules when one of their member's rehabilitation is at stake, some unions do their members a disservice instead of serving them. Instead of focusing the attention of their members on the legal aspects or a possible award by the industrial commission (since the basis for settlement does not terminate until many months after the employee returns to work) the counsellors would render far greater service by prevailing upon both employer and employee toward developing a suitable work program for those ready to return to some type of work.

Some employees, too, are resistant about returning to work before their "case is settled." They think they may lose their "rights" if they return to work. Obviously, such unsound attitudes stem from ignorance and can only be banished by frank discussion and explanation. They are more prone to develop in plants where cooperation by management has been lacking. Unscrupulous lawyers occasionally are at the root of the employee's refusal to return to work or failure to cooperate during treatment; the employee may be following his lawyer's instructions. When such instances are discovered the industrial commission should be notified and the local Bar Association as well.

Nor are the physicians always blameless. Too often is treatment conducted with little thought about early functional activation in the employee's work environment. Little effort may be made to intervene with the plant superintendent about arranging suitable work and in changing it as the empolyee's ability improves; or in developing a sound attitude in the employee and in pointing all therapy toward early, active use of those parts of his anatomy not affected by the injury.

All that has been said here is equally applicable to those partially disabled by disease, though here we have the additional barrier of the possibility of aggravation by a work factor with subsequent liability under existing compensation laws. Changes in the compensation laws and broadened second injury funds should be developed lest an altruistic employer be unjustly penalized.

Thus, it is seen that the loosely used term, *light work* yields to the broader concept of returning to *work*—work, it is true, that may be restricted in many ways, that may be specific for a given individual, that may be limited to the utilization of what the employee "has left"—so that one of the most important phases of treatment may be utilized, namely, early functional activation in the employee's work environment.

More effectively than any other approach, medicine and public health can build a conception of common human need, of the single destiny that awaits life on this planet, whether it be good or evil. We are members of one human family, fighting the same enemies of disease and suffering. Only by united effort can we survive, and the field of public health can be a practical demonstration of a new kind of teamwork. It can be a bridge across the gulf that separates this frightened present from a saner and better balanced future. Symbolically and literally it can bring its healing techniques to a human society that is desperately sick. Raymond B. Fosdick, Am. J. Pub. Health, Jan., 1948.

NEWS OF THE STATE



BUREAU COUNTY

Society News.—Dr. W. O. Thompson, Chicago, Rush clinical professor of medicine, University of Illinois College of Medicine, addressed the Bureau County Medical Society, Tuesday, May 18, at the Perry Memorial Hospital, Princeton, on "Common Sense in the Practice of Medicine." Dr. Adrien Verbrugghen, Chicago, discussed "Sympathectomy in Hypertension" before the society in Princeton, June 8. Dr. George E. Kirby is the program chairman and Dr. R. E. Davies, Spring Valley, is secretary of the Bureau County Medical Society.

CHAMPAIGN COUNTY

Hospital Staff Changes.—Dr. W. F. Lamkin, Champaign, was elected president of the medical staff of Burnham City Hospital succeeding Dr. Glen F. Fishel, Tolono. Other changes made at the meeting of the staff on May 19 include Dr. J. C. Dallenbach, Dr. T. G. Knappenberger and Dr. John H. Gernon, who were named to the executive board. Holdover members of the executive board are Dr. Joseph E. Sexton, Dr. M. M. Ricketts, Rantoul, and Dr. Earl D. Wise. Department heads appointed for the next year are Dr. L. T. Gregory, surgery; Dr. Marcus W. Hedgecock, eye, ear, nose and throat; Dr. Earl D. Wise, obstetrics; Dr. Eleanore Wright, pediatrics; and Dr. Willard L. Veirs, medicine.

CHRISTIAN COUNTY

Personal.—Dr. G. W. Arends, formerly of Mount Auburn, has become associated with Dr. W. A. Monaghan and Dr. E. C. Bartelsmeyer, Taylorville. Dr. Arends, after his release from military service, started his medical practice in Mount Auburn.

Change in Fees Scheduled.—At a meeting of the Christian County Medical Society, April 13, rearrangement of the fee schedule was undertaken. A copy of the new schedule, which includes an increase in fees for day calls and night calls and an increase in fees for calls on Thursday afternoons, Sundays and legal holidays was to be posted in physicians' offices on or before May 1, when the new schedule was to be in effect. The fees for other services have been increased accordingly. This is the first revision of fees in the Christian County Medical Society in thirty years, the increased costs of practice having been absorbed personally by the physician during recent years.

COOK COUNTY

Relation of Tight-Laced Corsets to Gastric Ulcer.—The Formfit Company of Chicago has awarded a research grant of $9,000 to the University of Illinois College of Medicine for studies designed to determine the relationship of the wearing of tight-laced corsets by women to gastric ulcers and other internal disorders.

The research program will be conducted by the University's department of Clinical Science, headed by Dr. A. C. Ivy. It will continue for approximately one year.

The project will include studies of gastric functions, the shape of the stomach, the rate at which the stomach empties, and the acidity of its gastric content before and after compression of the waist. Observations will be made by means of x-ray and fluoroscopy.

Students Awarded Prizes.—Eugene A. Rosenberger, junior medical student from Lakota, N. D., has been awarded the first prize of $25 by the department of orthopedic surgery at the University of Illinois College of Medicine for a paper written on the subject of "Painful Shoulder." Dr. Fremont A. Chandler, head of the department, also announced the awarding of the second prize of $15

to William R. Larson, Highland Park. The third prize of $10 was won by William Oyen, Chicago.

Dr. Ivy Named to Argonne Laboratory.—Dr. Andrew C. Ivy, vice president, University of Illinois in charge of the Chicago Professional Colleges, has been appointed to the board of governors of the Argonne National Laboratory for a period of three years. Dr. Ivy was nominated for the position by the unanimous vote of the Council of Representatives of the participating institutions of the laboratory. H. K. Stephenson, secretary of the board of governors, pointed out that the board felt that Dr. Ivy "would be well qualified to serve as representative of the biological field for their activities in directing the work of the Argonne National Laboratory."

Willard Gibbs Medal For Research.—The Chicago Section of the American Chemical Society awarded Dr. Carl F. Cori, St. Louis, the 37th annual Willard Gibbs medal in recognition of the research in how the body uses sugar.

Research Grants.—G. D. Searle and Company, Chicago, has awarded a grant of $2,500 to the University of Illinois College of Medicine to assist in a research project to be carried out under the direction of Dr. Andrew C. Ivy, vice president in charge of the Chicago Professional Colleges, University of Illinois College of Medicine. The research project involves the study of the incidence of colonic dyskinesis and its management with the hydrophilic colloid in patients with peptic ulcer.—The VioBin Corporation of Monticello has presented a gift of $1,000 to the University of Illinois College of Medicine for use by Dr. Ivy. Dr. Ivy said that the contribution would be used for research work on the effect of substances in the mucosa of the stomach and duodenum.

Society News.—Dr. Maurice H. Cottle conducted a class in "Reconstructive Surgery of the Nasal Septum and Nose" for the Ear, Nose and Throat Society, of Shreveport, Louisiana, May 16-19.—Dr. Philip Thorek presented a paper on "Jaundice" with colored motion picture and slide demonstration before the Wayne University College of Medicine, Annual Alumni Clinic Day, in Detroit, May 12.—Dr. Richard Meade, Michigan, gave the Annual Hedblom Lecture at the University of Illinois College of Medicine under the auspices of the Phi Beta Pi Medical Fraternity, May 19, on "Principles Underlying the Management of Chest Injuries."—Dr. Meyer A. Perlstein addressed the State University of Iowa College of Medicine, Iowa City, April 3, on "Etiology of Cerebral Palsy." He also conducted clinics at the Couzen's Children's Center in Traverse City, Mich., May 11.

Personal.—Effective May 1, Dr. Charles T. Dolezal, superintendent of Cleveland's City hospital, became assistant director and secretary of the council on professional practice of the American Hospital Association. Dr. Dolezal succeeds Dr. Hugo V. Hullerman, resigned. In his new position, Dr. Dolezal will work toward standardization and improvement of procedures of various professional staffs in hospitals and in the interests of improved efficiency and better patient-care, confer with representatives of national organizations of these professions and with hospital officials.—Dr. Anthony Bolino, Chicago, has become associated with Dr. S. J. Plucinski in Argo.

Dr. Olaf Bergeim Appointed Chairman of Committee on Radioisotopes.—Six faculty members of the Chicago Professional Colleges, University of Illinois, have been appointed to examine and approve all proposals of research work or therapeutic investigations involving the use of radioisotopes on the campus.

The committee has been established along the lines suggested by the U. S. Atomic Energy Commission.

Dr. A. C. Ivy has appointed Dr. Olaf Bergeim, professor of biological chemistry, as chairman of the committee.

Dr. Roger A. Harvey, a radiologist qualified in the techniques of radioisotopes, will serve as vice-chairman. The secretary will be Dr. H. L. Davis, who is qualified through his experience in connection with the Manhattan project to advise on the proper selection and measurement of isotopes, as well as problems of preparation and of extraction for measurement.

Other members of the committee are Dr. Louis R. Limarzi, an authority on the physiology and pathology of blood-forming organs; Dr. Ford K. Hick, who is well-versed in metabolism and metabolic disorders; and Dr. E. E. Painter, who has been associated with the atomic bomb project at the University of Chicago since 1943, and who still serves as a consultant for the biology section of the Argonne National Laboratory.

The chairman and vice-chairman of the committee are authorized to approve and forward requests to the Isotope branch of the Atomic Energy Commission at Oak Ridge, Tenn.

The committee has approved the request of Dr. Bergeim for permission to order isotopes in connection with the work of his group on iron absorption. The committee expressed its approval of the make-up of the research team, of the space assigned, of the health and safety provisisions available, and the merits of the problem. Approval of Dr. Painter's work involving the use of radioactive sodium in short-term experiments on rats also has been granted.

The committee will cooperate fully with the committee on isotopes at the Champaign-Urbana campus of the University of Illinois.

Dr. Voight Curator of Pollen Collection.—According to the Faculty Newsletter of the Chicago Professional Colleges of the University of Illinois, Dr. Ralph F. Voight has been named curator by the American Academy of Allergy for a collection of allergenic pollen and specimens of all plants producing hay fever throughout the United States.

The Academy is now collecting and also receiving from other collectors authentic material from all possible geographical sources in the country.

The samples of pollen and their respective herbarium specimens which are received will be kept by the University of Illinois college of pharmacy at its proposed Drug Plant Experimentation Station. The Station will be located at Lisle, Illinois, 25 miles west of the Medical Center District.

The collection will be supervised by the sub-committee of Allergenic Pollens and Herbarium for the American Academy of Allergy. The sub-committee is headed by Mr. O. C. Durham, chief botanist of the Abbott Laboratories and a member of the faculty of the University of Illinois college of pharmacy. Other members of the sub-committee are Dr. A. O. Dahl of the University of Minnesota and Dr. Voight.

Acording to plans, physicians and research workers who are directly connected with the work of aero-allergens will be able to obtain authentic slides of the various pollens that are common to their particular geographical area as they are made available.

Physician's Gift Begins Nucleus for Library.—Dr. Thomas D. Allen recently donated fifty books and a large number of complete sets of ophthalmological journals to the Illinois Eye and Ear Infirmary. The publications will serve as a nucleus for an ophthalmological library to be initiated at the Infirmary.

State Tuberculosis Hospital.—First elevation drawings of the exterior of the state-operated five million dollar tuberculosis hospital to be erected in the Medical Center District have been completed. The facility will be nine stories high, and built of gray brick with stone trim. It will be placed on the north half of the landscaped 10-acre tract which is now being purchased in the area bounded by Roosevelt road, Taylor street, Damen avenue and Wolcott avenue. Mr. C. Herrick Hammond, state supervising architect, and Mr. Philip B. Maher, associate architect, have arranged the plans to give the hospital a 557-bed capacity, 57 more than formulated in the original plans.

News of the Specialty Groups.—New officers of the Chicago Ophthalmological Society chosen at a meeting April 19, include the following Chicago physicians: Arlington C. Krause, president; George P. Guibor, vice-president; Cyril V. Crane, secretary-treasurer; and Richard C. Gamble, corresponding secretary.—At the recent meeting of the Chicago Urological Society, Dr. James W. Merricks was elected president, Dr. James I. Farrell, vice-president, and Dr. J. S. Grove, secretary-treasurer.—The Chicago Society of Internal Medicine elected the following officers at its annual meeting on May 24: Dr. George H. Coleman, president; Dr. Howard L. Alt, vice-president; Dr. Ernest G. McEwen, secretary-treasurer.

Dr. Armstrong Heads Department of Medicine.—Dr. S. Howard Armstrong Jr., of Boston, has been appointed fulltime chairman of the department of medicine at Presbyterian Hospital and will devote most of his time to the hospital's enlarged program of medical research, newspapers report. Dr. Armstrong will direct equipping of the hospital's new laboratory of medicine. A graduate of the Harvard University Medical School, he has devoted the last seven years to graduate study of internal medicine at Harvard and the Massachusetts Institute of Technology.

Ground Broken for Hospital.—Ground has been broken for the Nathan Goldblatt Memorial Hospital, a part of the University of Chicago cancer research center. The Lawndale Ladies Aid recently presented a check for $2,100 toward endowing one room in the hospital. The hospital is being financed in part by a gift of $1,000,000 by the Goldblatt Brothers Foundation.

Loyola Changes Name.—The Loyola University School of Medicine has been changed to the Stritch School of Medicine of Loyola according to a newspaper announcement May 11. The announcement was made coincident with the launching of a campaign to raise approximately six million dollars to house the medical and dental schools in the west side medical center. Loyola University is one of the five Catholic medical schools in the United States. The new building to house the medical and dental schools will be erected at Ogden Avenue and Harrison Street. The Loyola University Medical School is now located at 706 South Wolcott Avenue and the dental school at 1757 West Harrison Street.

Mercy Hospital Opens Cancer Clinic.—Chicago's first cancer detection clinic with facilities for both men and women was opened April 27 at Mercy Hospital under the auspices of the Illinois Division of the American Cancer Society. In addition to conducting examinations each day the clinic will be opened Tuesday nights for women and Thursday nights for men. The Illinois Division presented a check for $4,000 to Dr. Herbert E. Schmitz, vice president of the society and head of Mercy's X-ray and cancer department.

New Head of Pharmacognosy and Pharmacology.—Dr. Frank T. Maher has been named head of the department of pharmacognosy and pharmacology at the University of Illinois College of Medicine, effective September 1. Dr. Maher, now on leave from the university, is serving as a research associate at the Mayo-Research Foundation, Minnesota.

Special Grants for Research.—The Abbott Laboratories of Chicago have awarded separate research grants of $4,550 and $2,850 to the University of Illinois College of Medicine in support of investigations under the direction of Dr. Milan V. Novak, head of the department of bacteriology and public health. The larger grant has been made in support of investigations in the evaluation of procedures and germicides in the preoperative preparation of the surgeon and the patient. Dr. Novak has

indicated interest in studying the skin bacteria in normal individuals by quantitative methods, and determining their ability to reappear on cutaneous surfaces in significant numbers after preoperative removal by germicidal treatment.

The second grant of $2,850 will be used for the evaluation of particle size of penicillin-procaine complex as related to effective blood levels in human patients. Patients requiring penicillin therapy will receive the benefit of considerable quantities of penicillin which the Abbott Laboratories will provide at no charge. The investigation will be administered by Dr. Novak with the cooperation of Dr. Robert W. Keeton, Dr. E. Hale, and Miss Betty Spaeth in clinical and laboratory phases.

DE KALB COUNTY

Society Meeting.—Dr. Philip Thorek, Chicago, addressed the De Kalb County Medical Society in Sandwich, May 25, on "Intestinal Obstruction" with colored motion picture demonstration.

DOUGLAS COUNTY

Tuberculosis Program.—Dr. Joseph Maher, director of the Vermilion County Tuberculosis Sanatorium, Danville, addressed a county-wide meeting Monday evening, May 17, at the Chamber of Commerce Rooms, Tuscola. It was announced at this meeting by Dr. C. K. Ross, Newman, president of the Douglas County Medical Society, that free chest X-rays will be offered to all citizens of Douglas County who are over the age of 14 years. The mobile X-ray unit will be sent throughout the county under the auspices of the county medical society and the Douglas County Sanatorium Board.

Cancer Committee Created.—The Douglas County Medical Society has organized a medical cancer committee with Dr. Edmund Kahan, Hindsboro, as chairman and Dr. James Taylor, Villa Grove, and Dr. Phillip Deaver, Tuscola, as members. They will act as medical advisers to the chapter lay committee which Mrs. R. E. Fildes, state representative of the American Cancer Society, is now organizing from towns throughout the county.

HENRY COUNTY

Fifty Years of Practice.—The Henry County Medical Society and its woman's auxiliary honored Dr. and Mrs. Gideon H. Hoffman at a dinner at the Hotel Kewanee, May 3, in celebration of the fiftieth anniversary of the practice of medicine of the physician. Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District of the Illinois State Medical Society, was the principal speaker and presented Dr. Hoffman with the emblem and certificate of the Fifty Year Club of the Illinois State Medical Society. Dr. John T. Boswell acted as toastmaster. Following the dinner honoring Dr. Hoffman, the Henry County Medical Society held its annual election. Dr. A. W. Wellstein, Geneseo, was named president, Dr. Nolan Montgomery, Kewanee, vice president and Dr. C. Paul White, Kewanee, was reelected secretary-treasurer. Dr. White was also named as delegate to the Illinois State Medical Society for the next two years and Dr. Hoffman was elected alternate.

JERSEY COUNTY

Personal.—Dr. F. Gorecki, former practicing physician in Chicago, has opened offices in Jerseyville.

MACON COUNTY

Society Approves Health Department.—The executive committee of the Macon County Medical Society has recommended that the Society approve a plan to establish a county health department. According to the Decatur Review, about $90,000 or one dollar per capita would be needed to finance a county health department. Of this amount, 20 per cent or $18,000 would be provided by the Illinois department of public health. To provide the county's share the county board of supervisors would levy an annual tax not to exceed five cents per $100 of all taxable property in the county. In Macon County the health department would be shifted from the city government to the county board of supervisors and would be managed by a board of seven members appointed by the supervisors. Of this number, two must be physicians and one a dentist. A full staff for the county would include a county health officer, three sanitary officers, a public health nurse supervisor, 17 assistant public health nurses, a health educator and a clerk-stenographer. Such a change would involve reorganization of several existing facilities and considerable duplication of effort, facilities and equipment could be avoided, according to the report.

Society News.—Dr. Ralph E. Dolkart, assistant professor of medicine, Northwestern University Medical School, addressed the Macon County Medical Society at the St. Nicholas Hotel, May 25, on "Clinical Problems in Antibiotic Therapy."

MADISON COUNTY

Colleagues Honor Fifty Years of Medicine.—Dr. M. W. Harrison, Collinsville, was guest of honor, April 21, in a special observation commemorating fifty years in the practice in medicine, practically all of which was spent in Collinsville. Dr. Harrison was mayor of Collinsville for twelve years and had been a member of the board of education for many years. Dr. Julius Verneuil, Collinsville, was master of ceremonies. Dr. Walter Stevenson, Quincy, presented Dr. Harrison with the emblem and certificate of the Fifty Year Club of the Illinois State Medical Society.

MARION COUNTY

Personal.—Dr. W. H. McCain, who has practiced in Centralia since 1937, has moved to Pana.

MERCER COUNTY

Society Secretary Named to Presidency.—Dr. V. A. McClanahan, Aledo, was recently elected president of the Mercer County Medical Society, to succeed Dr. C. M. Murrell, Sherrard. Dr. James

W. Hastings, Aledo, vice president and Dr. Nellie E. Marsh, Aledo, secretary-treasurer, were reelected to their respective positions. Dr. McClanahan, who has been practicing fifty-two years, has been secretary of the Mercer County Medical Society for more than twenty-five years, retiring this year at his own request. He is also coroner of the county.

PEORIA COUNTY

Personal.—Dr. G. W. Giebelhausen, recently released from the United States Army, has entered practice of medicine with Dr. Anton P. Huml, in Peoria.

Society News.—Edward H. O'Connor, managing director of the Insurance Economic Society, Chicago, addressed the Peoria County Medical Society, June 2, on "What Socialized Medicine and Compulsory Health Insurance Means to You."

ROCK ISLAND COUNTY

Society News.—"The Importance of Breast Feeding" was the subject of an address by Dr. Robert Jackson, associate professor of pediatrics, State University of Iowa College of Medicine, Iowa City, before the Rock Island County Medical Society, May 18, at the Moline Public Hospital.

Fifty Year Members.—Five physicians of the Rock Island County Medical Society were elected to the Fifty Year Club of the Illinois State Medical Society at a meeting in the Moline Public Hospital, May 18. The physicians were Dr. John W. Seids and Dr. Arthur D. West, both of Moline, Dr. Frank H. First, Rock Island and Dr. George F. Johnson, East Moline. Dr. Benjamin B. Marquis, Buffalo Prairie, was not present. Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District of the State Medical Society, made the presentations.

STEPHENSON COUNTY

Society Urges Examinations for Food Handlers.—The city council of Freeport, on the recommendation of the Stephenson County Medical Society, has requested its legal affairs committee to draw up an ordinance requiring semi-annual health examinations for all public food handlers, barbers and beauty operators.

VERMILION COUNTY

Special Day Honors Physician.—The citizens of Muncie and the surrounding community observed "Dr. O. W. Michael's Day", Sunday, April 25, the day marking the completion of fifty years in the practice of medicine of the physician. A public ceremony was held in local high school. The eulogy was presented by Dr. A. E. Dale, Danville. Among the many gifts given to the physician were a large humidor with engraved plate from the members of the school board and a gold-handled knife, with gold chain, from the high school faculty. Dr. Michael for thirty-three years was head of the Oakwood Township High School board of education and a founder of the school in 1915.

WILL COUNTY

15,000 Will County School Children Examined for Sub-Normal Hearing.—More than 15,000 school children in Will County already have been examined for sub-normal hearing in a project which is under the supervision of the state-wide Advisory Committee on Hearing Conservation and Rehabilitation according to the Faculty Newsletter of the Chicago Professional College of the University of Illinois.

Dr. Charles K. Kincaid, Will County health officer, has reported that approximately eight percent of the children tested have been referred for otological examination because of hearing loss. Dr. Kincaid pointed out that "the hearing losses in some were due simply to the presence of excess wax, and in others were due to temporary and insignificant conditions." Sixty-nine were reclassified as normal. A total of 15,384 have been tested since the beginning of the program in Will County on November 3, according to Dr. Kincaid. The remaining 5,000 school children in the county were to be tested by the end of the present school year. Examinations have been completed in 18 city schools, 18 village schools, 23 parochial schools, and 84 rural schools. Representatives of 10 organizations and units throughout the state, including the University of Illinois, are cooperating in the program which has been organized to also provide continuous follow-up care. It provides educational and vocational guidance for many years after the initial procedures have been completed. The unique project employs methods of case finding and structures a clinical re-educational service program. It will serve as a model for future programs in other counties of the state.

Personal.—Dr. William H. Cave recently associated with Dr. W. V. Hedges and Dr. Claude Otto in Frankfort. Dr. Cave was born in Illinois but recently came from Greenville, Miss.

WINNEBAGO COUNTY

Personal.—Dr. Alfred C. Meyer, who was stationed at Camp Grant during the war, has engaged in the practice of medicine in Rockford.

GENERAL

Heart Group Chooses Officers.—Dr. Harry Durkin of Peoria was re-elected president of the Illinois Heart Association at the Association's annual meeting held at the Palmer House, Chicago, Monday evening, May 10. Dr. Frank Deneen of Bloomington was re-elected vice president, Dr. Don C. Sutton of Chicago, secretary, and Dr. Lewis W. Woodruff of Joliet, Treasurer.

Speaking at the meeting, Dr. Louis N. Katz, director of cardiovascular research at Michael Reese Hospital, outlined objectives of research, for which the Illinois Heart Association and its parent organization, the American Heart Association, are raising funds. "There are three fundamental problems that must be solved," Dr. Katz said. "First,

what is rheumatic fever? Second, why high blood pressure, and what is it? Third, what is hardening of the arteries and what causes it? Researchers frequently have crazy ideas, but it is in exploring these crazy ideas that we will find the ultimate solution to these mysteries.

"We need to emphasize the psychology of hope in connection with diseases of the heart and circulation, instead of the psychology of fear," Dr. Katz stated. "We must tell people about the use of surgery and diet in high blood pressure, of the promising use of penicillin and streptomycin in certain types of heart disease, of surgery in congenital heart disease, that thyroid heart disease is reversible, that syphilitic heart disease would disappear if everybody were properly educated."

Laymen were elected to the Association's Board of Directors for the first time. The following physicians and laymen were elected:

Charles E. Becker, Springfield; Dr. Herman Cole, Springfield; Henry F. Driemeyer, East St. Louis; Dr. Robert W. Elliott, Alton; Herman Lewis, Champaign; Richard Moss, Belleville; Harry J. Neumiller, Peoria; Dr. George W. Parker, Peoria (re-elected); Dr. Emmett Pearson, Springfield; Dr. Fred Rose, Belleville; Dr. LeRoy Sloan, Chicago (re-elected); Dr. Edgar Stevenson, Bloomington (re-elected); Dr. Harry K. Warren, Peoria; Mrs. George Woodruff, Joliet; Dr. Lewis W. Woodruff, Joliet (re-elected).

Rotary Club Devotes Session to Tuberculosis.—The Rotary Club of Chicago, at its meeting in the Sherman Hotel, June 1, considered "Tuberculosis: Its Problem and Solution." The speakers were Drs. Morris Fishbein, Editor of The Journal of the American Medical Association; Herman N. Bundesen, Health Commissioner and President of the Chicago Board of Health, and James H. Hutton, Chairman of the Committee on Tuberculosis Control, Chicago Medical Society, who acted as chairman.

Officers of Obstetrical Group.—Dr. W. C. Scrivner, East St. Louis, was chosen president-elect of the Illinois Obstetrical and Gynecological Society at a meeting, May 9, in Chicago. Dr. E. N. Nash, Galesburg, is president of the society. Other officers include Dr. Otis Smith, Oak Park, vice-president; Dr. G. H. Edwards, Pinckneyville, secretary; Dr. George B. Callahan, Waukegan, treasurer and Dr. W. I. Louis, Herrin, historian. Dr. Scrivner is president of the St. Clair County Medical Society.

College of Surgeons to Meet in Los Angeles.—The thirty-fourth Clinical Congress of the American College of Surgeons will be held in Los Angeles, with headquarters at the Biltmore Hotel, from October 18 to 22, 1948. The program of scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurological surgery, will be supplemented by operative clinics in hospitals in Los Angeles and vicinity by showings of operations by television and motion pictures, and by a four-day hospital standardization conference for hospital personnel, according to Dr. Irvin Abell of Louisville, Chairman of the Board of Regents of the College. There will also be extensive technical and scientific exhibits.

New officers who will be inaugurated at the opening evening session are Dr. Dallas B. Phemister, Chicago, President; Dr. Howard A. Patterson of New York, First Vice President; and Dr. Carl H. McCaskey of Indianapolis, Second Vice President. The outgoing officers are Dr. Arthur W. Allen of Boston, President; Dr. Thomas E. Jones, First Vice President; and Dr. Gordon B. New, Rochester, Minnesota, Second Vice President. The other officers of the College are Dr. Paul B. Magnuson of Washington, Secretary; Dr. Bowman C. Crowell and Dr. Malcolm T. MacEachern of Chicago, Associate Directors; and Dr. H. Prather Saunders and Dr. Charles F. Branch, Assistant Directors. Dr. Phemister is Treasurer.

At the Convocation which will be held on the final evening of the Clinical Congress, some 600 initiates will be received into fellowship. The American College of Surgeons, which was organized in 1913 to elevate the standards of surgery, now has a total fellowship of more than 15,000 surgeons in North, Central, and South America, and in a few other countries.

FROM THE DEPARTMENT OF HEALTH

Prevalance of Communicable Diseases.—Although Illinois has experienced epidemic waves of both measles and mumps so far this year, residents of the State have fared well with regard to most other communicable diseases, Dr. Roland R. Cross, state director of public health, reported today..

Particularly noteworthy are the gains made against the common preventable diseases of childhood. During the first 18 weeks of 1948, 35 cases of diphtheria were reported to the State Department of Public Health, as against 75 cases in the comparable period of last year, a reduction of more than 50 per cent. Likewise, whooping cough case reports have declined by about one-third, dropping from a total of 1,534 in the first 18 weeks of 1947 to 1,019 in the same period this year.

Not a single case of smallpox has been reported so far this year, and only 26 cases of typhoid fever have been recorded, as against 50 cases in the comparable weeks of 1947.

Dr. Cross pointed out that every one of these diseases — diphtheria, whooping cough, smallpox and typhoid fever — can be easily prevented, and preventive preparations are available, without charge, from the state department of public health or through any local health department.

Significant also in the report is the marked reduction in prevalence of the respiratory diseases. Pneumonia and influenza have been responsible for 2,092 cases of illness so far this year, as com-

pared with 3,133 cases in the corresponding period of 1947. Tuberculosis also declined from a total of 2,592 cases in the 1947 period to 2,075 this year.

Poliomyelitis is about one-third as prevalent as last year, with 10 cases reported as against 33 in the 1947 period. Scarlet fever has declined from a total of 2,468 cases in the first 18 weeks of last year to 2,404 in 1948.

With about 300 cases of syphilis and approximately 500 cases of gonorrhea reported weekly, the venereal diseases are also running well under last year's figures.

"FOR THE COMMON GOOD"

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society; Charles P. Blair, Monmouth, Chairman:

"The Doctor and His Medical Society", the exhibit of the Illinois State Medical Society was on display for three days in the Sherman Hotel, Chicago, during the annual meeting of the Illinois Federation of Women's Clubs at the request of Mrs. Warren H. Lutton, state health chairman of the Federation. Mrs. Lutton has completed her term as health chairman and has been succeeded by Mrs. Frank Christiansen, Sycamore. Both women were visitors in the Chicago office of the Illinois State Medical Society, June 7.

Hundreds of HEALTH TALK were made available to numerous Health and Summer Round-Up Chairmen of the Illinois Congress of Parents and Teachers for distribution in their respective round-ups.

Joseph Bertucci, Chicago, Howe School PTA, May 20, "We Learn to Safeguard Our Children's Health."

Walter C. Bornmeier, Chicago, Ryburn King Hospital in Ottawa, May 28, "A 'Hypo' for Hippocrates."

Adrian D. M. Kraus, Chicago, Fort Dearborn PTA in Chicago, October 13, "How the Parents of the School Can Make Our Health Program More Effective by Encouraging Protection through Immunization."

Emmet Keating, Chicago, Schubert School PTA in Chicago, October 20, on "Heart Disease."

Mr. John Neal, Woman's Neighborhood Club of Rogers Park in Chicago, December 3, on "Socialized Medicine—Threshold of the Welfare State."

Postgraduate Conferences Under the Auspices of the Postgraduate Education Committee; Robert S. Berghoff, Chicago, Chairman:

The Council of the Illinois State Medical Society has authorized twelve postgraduate conferences in ten of the eleven Councilor Districts of the state for the 1948-1949 season. Secretaries of County Medical Societies wishing to have one of these conferences should communicate with the Councilor of their District.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman:

Samuel M. Bluefarb, Chicago, Livingston County Medical Society in Dwight, June 3, on "Cutaneous Manifestations of Diseases of the Blood."

Mr. Thomas A. Hendricks, Secretary, Council on Medical Service, American Medical Association, Chicago, Champaign County Medical Society in Champaign, June 10, "Free Wheeling in the Field of Medical Economics."

Dr. William M. McMillan, Chicago, Kane County Medical Society in Aurora, June 9, on "Surgery of Hypertension."

Eugene T. McEnery, Chicago, Fulton County Medical Society in Canton, June 11, "Care of the Newborn."

Paul Starcevich, Chicago, Franklin, Perry, Randolph, Union and Williamson with Jackson County Medical Society acting as host in Murphysboro, June 17, on "Diseases of the Gallbladder."

John Van Prohaska, Chicago, La Salle County Medical Society in La Salle, September 9, "Surgical Management of Ano-Rectal Diseases."

DEATHS

THEODORE LEE AGNEW, Ogden, who graduated at Marion-Sims College of Medicine, St. Louis, in 1895, died in his home, May 7, aged 77. He had been in ill health for several years.

CHARLES EDWARD COLE, Jacksonville, who graduated at Northwestern University Medical School in 1903, died May 10, at Passavant Hospital, aged 69. He had sustained a broken hip in a fall at his home several weeks before his death. He had been instrumental in the building and maintenance of Oaklawn sanatorium and had served as a board member since the time of its founding.

WILLIAM JOHN CROTTY, East St. Louis, who graduated at St. Louis University School of Medicine in 1919, died suddenly in his home of a heart attack May 22, aged 54. He was on the staffs of St. Mary's and Christian Welfare Hospitals.

FRANK CLARK DODD, retired, Clayton, who graduated at Rush Medical College in 1900, died April 24, aged 81.

OTTO GRANVILLE DRAPER, Chicago, who graduated at Missouri Medical College in 1898, died recently, aged 79. A native of Macon, Misouri, Dr. Draper had practiced medicine in Chicago for 48 years at the time of his retirement last fall.

JOHN WESLEY ECKMAN, Winchester, who graduated at the University of Illinois College of Medicine in 1908, died May 11, aged 66. He had practiced medicine in Winchester 38 years.

FREDERICK HENRY HARNAGEL, Chicago, who graduated at St. Louis University School of Medicine,

1912, was found dead in a hotel at Pontiac, February 10, aged 61, of coronary thrombosis.

Lyford McChesney Johnson, Arrowsmith, who graduated at University of Illinois College of Medicine in 1903, died April 30, aged 67, at St. Joseph Hospital, Bloomington, where he had been a patient since March 1. He founded the L. M. Johnson Hospital in Arrowsmith in 1921 and was a member of the staffs of St. Joseph's Mennonite and Brokaw Hospitals; Bloomington.

John Virgil McKim, Bowen, who graduated at St. Louis College of Physicians and Surgeons, St. Louis, in 1895, died May 24, aged 76, in St. Mary's Hospital, Quincy, where he had been a patient since April 27. He had practiced medicine in Bowen for 15 years.

Nina Polson Merritt, Alton, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1901, died January 8, aged 75.

Thomas Morgan, Alton, who graduated at Baltimore Medical College in 1895, died in St. Joseph's Hospital, February 1, aged 76, of injuries he received when struck by an automobile while he was crossing the street.

Herbert LeRoy Pettitt, Morrison, who graduated at the University of Illinois College of Medicine in 1906, died May 6, aged 72, of coronary occlusion. He had served as assistant director of the Illinois Department of Public Health from 1941 to 1942; was chief medical officer for the Illinois War Council since 1942; formerly served as Whiteside County Physician; was president of the Whiteside County Tuberculosis Society for 10 years; member and past president of the Morrison Rotary Club; a veteran of World War I when he served as a first lieutenant in the medical corps of the United States Army.

John Ezra Phillips, Ewing, who graduated at St. Louis University School of Medicine in 1903, died May 8, aged 75. Had practiced medicine in Franklin County for 40 years.

Eva Prescott, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1903, died February 3, aged 71.

David B. Rotman, Chicago, who graduated at Loyola University School of Medicine in 1925, died May 30, aged 55. He was director of the Municipal Court Psychiatric Institute; served in World War II as a lieutenant in the medical corps; resident and senior physician at Chicago State Hospital until 1932.

William Lester Smith, Senior Surgeon, U. S. Public Health Service, retired, Carbondale, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1906, died in the U. S. Marine Hospital in Kirkwood, Mo., February 15, aged 65, of pneumonia.

John R. Thompson, Bridgeport, who graduated at the Hospital College of Medicine, Louisville, Ky., in 1902, died May 14, aged 70, of coronary occlusion. He had been a member of Lawrence County Medical Society for 30 years.

Charles Henry Voorheis, Hutsonville, who graduated at Rush Medical College in 1893, died April 16, aged 83, in Brooks Hospital, Robinson. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

John Edward Walton, Alton, who graduated at Marion-Sims College of Medicine, St. Louis, in 1897, died January 25, aged 80, of coronary occlusion. He was a past president of the Madison County Medical Society, member and formerly chief of staff of Alton Memorial Hospital and served during World War I.

Jacob H. West, retired, Champaign, who graduated at Cooper Medical College, California, in 1894, died May 2, aged 80, in Memorial Hospital, Springfield. He had practiced medicine in Champaign 31 years until his retirement in 1947.

Walter B. Whipple, Peoria, who graduated at Chicago College of Medicine and Surgery in 1904, died suddenly, April 25, at Proctor Hospital. He was 65.

Earl W. Williamson, Chicago, who graduated at the University of Illinois College of Medicine in 1919, died May 10, aged 63, of a heart attack at Joliet on a Chicago bound train. He was assistant associate director of the American College of Surgeons.

Much could be learned about the epidemiology of tuberculosis if we could encourage the participation of more general practitioners in field studies throughout the country. The routine use of the tuberculin test on every person who visits the rural doctor's office would uncover a surprising number of hidden and unsuspected cases of tuberculosis. The examination of family contacts and a search for the original spreader leads the family physician away from his relentless daily routine into exciting by-paths of epidemiologic investigations. Through the utilization of modern methods of diagnosis and follow-up the rural physician extends the frontiers of knowledge of this puzzling disease. Herman E. Hilleboe, M. D., Journal-Lancet, June, 1947.

the unique surface anesthetic

'Surfacaine' (Cyclomethycaine, Lilly) produces an unusually powerful surface anesthesia on damaged or diseased skin and on rectal, vaginal, urethral, and bladder mucous membranes within a few minutes after application. Anesthesia usually persists for four to eight hours and may be made continuous with regular applications. Systemic toxicity has not been observed in extensive clinical usage, even when the drug is applied to burns covering a large part of the body surface. Allergy to 'Surfacaine' is rare. The following pharmaceutical forms, for every indication, are provided on the physician's specification:

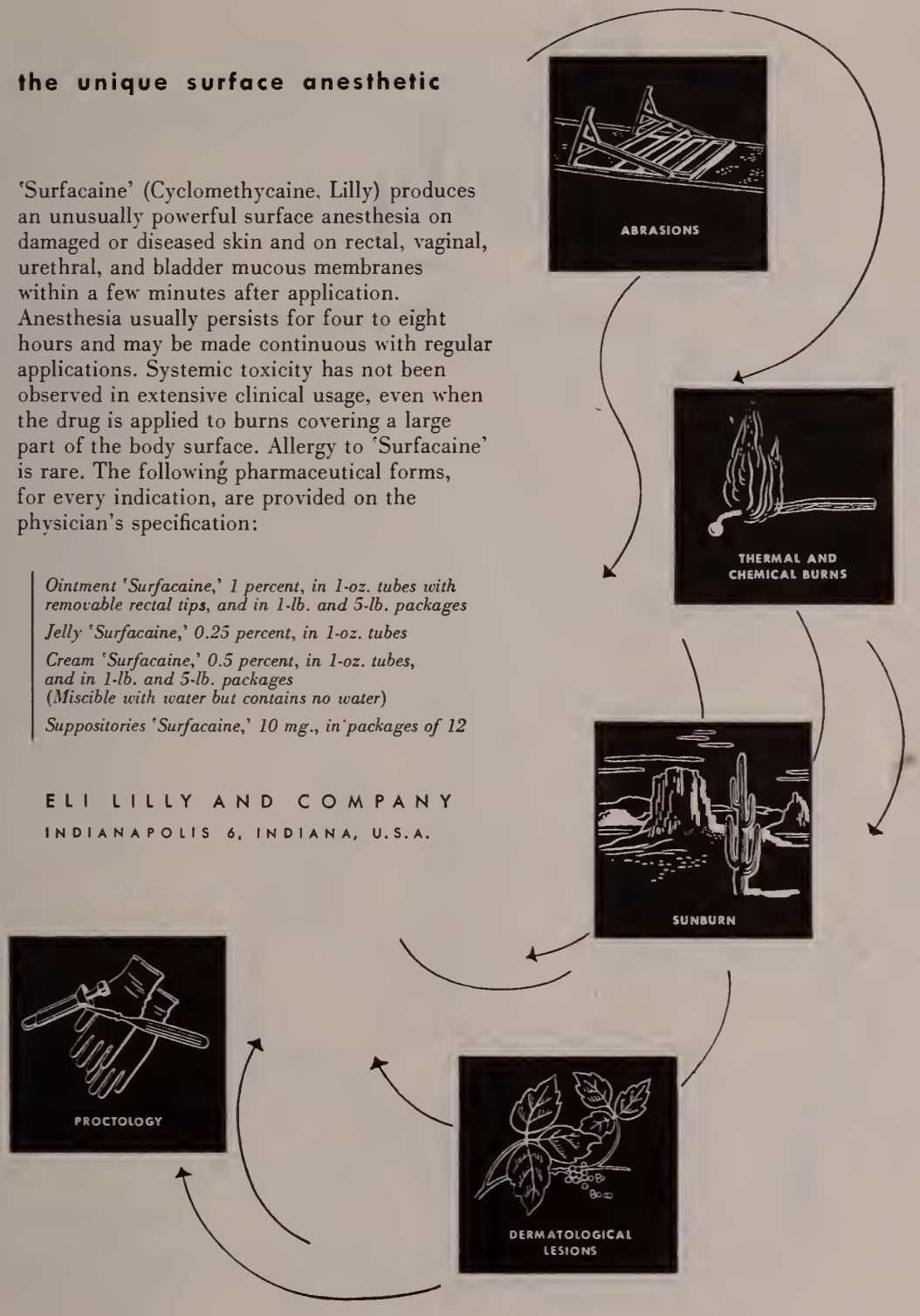
Ointment 'Surfacaine,' 1 percent, in 1-oz. tubes with removable rectal tips, and in 1-lb. and 5-lb. packages

Jelly 'Surfacaine,' 0.25 percent, in 1-oz. tubes

Cream 'Surfacaine,' 0.5 percent, in 1-oz. tubes, and in 1-lb. and 5-lb. packages (Miscible with water but contains no water)

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Candy AND CHANGING Energy REQUIREMENTS

THE widely varying demands imposed upon the organism by physical activity cannot always be met by even a well-balanced dietary, since food requirements are based on average daily needs.

Following periods of strenuous physical activity in play, games or work, when the usual stores of carbohydrate energy may become temporarily depleted, both children and adults find pleasure in turning to candy as a source of quickly available food energy. Not only are the metabolic demands met by the easily digested, quickly utilized nutrients in candy, but appetite is also momentarily appeased..

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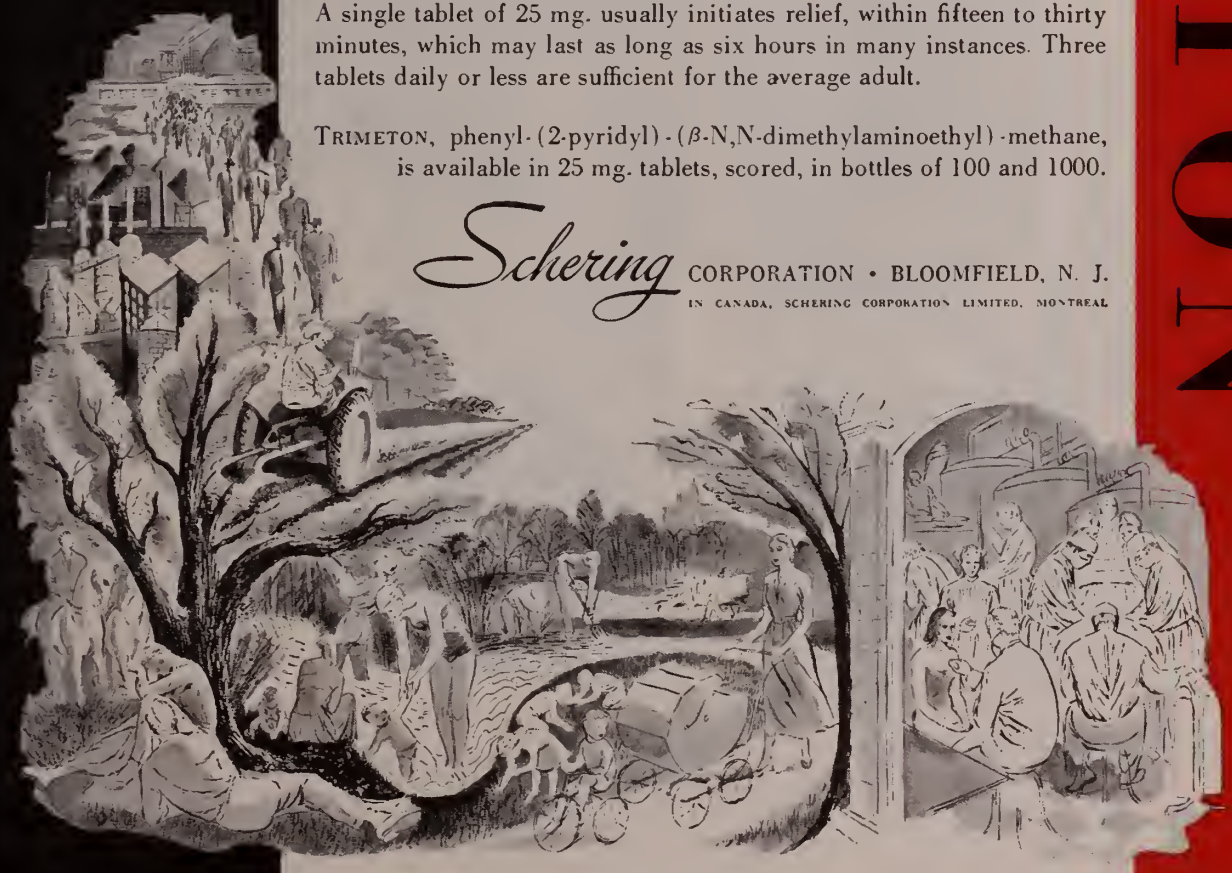
TRIMETON not only meets the demand for a preparation with fewer side effects, but it is also approximately twice as potent as other available antihistaminics. Selected by Schering's research staff after four years of experimentation TRIMETON has been thoroughly tested in the laboratory and clinic. TRIMETON provides the allergic individual with rapid and prolonged relief from hay fever, allergic rhinitis, urticaria, allergic eczema, and some cases of asthma.

A single tablet of 25 mg. usually initiates relief, within fifteen to thirty minutes, which may last as long as six hours in many instances. Three tablets daily or less are sufficient for the average adult.

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A balanced saline combination which acts by simple osmosis to dilute fecal residue and produce soft fluid bulk . . .

Stimulates peristalsis and promotes *speedy* but *gentle* evacuation.





**Aperient*

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**Average dose*

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Remarkable results in dysmenorrhea

highly effective in the relief of pain

In a clinical study extending over a period of a year, Long* used Edrisal as the sole medication in treating 630 employees for dysmenorrhea. Results were dramatic. He concluded, "We use it [Edrisal] with the knowledge that nine out of ten sufferers will get the relief they seek."

Edrisal combines the recognized analgesics—acetylsalicylic acid and phenacetin—with the unique anti-depressant, Benzedrine Sulfate. Consequently, it not only relieves the pain during the menstrual period, but also combats the accompanying psychic depression.

Best results are usually obtained with a dosage of *two* tablets, repeated every three hours, if necessary.

*Long, C.-F., M.D.: Edrisal in the Management of Dysmenorrhea, Indust. Med. *15*:679 (Dec.) 1946. Indust. Nurs. *5*:23 (Dec.) 1946.

Edrisal

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Philadelphia

PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER



MANAGEMENT OF PERIPHERAL VASCULAR DISEASE

Nathan Bloom, M.D., Richmond, Virginia. In Virginia Medical Monthly. Page 248. May, 1948.

When at rest the lower extremities should be in a horizonal position with a small pillow under the knees. The feet will then be slightly de pendent and about six inches below the level of of the heart, which is the best position for circulatory efficiency. At this level there is very slight distention of the veins on the dorsum of the foot. The patient is also advised to limit his walking or other active exercises to the minimum and is not allowed to sit with his knees crossed, as this will cause pressure on the popliteal arteries.

We advocate the Buerger type of passive vascular exercise. The patient is advised to perform the exercises three times a day, keeping the limbs elevated at a forty-five degree angle until there is beginning pallor of the feet. This usually takes one to two minutes. The limbs are then placed in a dependent position until rubor appears. This usually takes from three to five minutes. The limbs are then placed in a horizontal position for five minutes. The entire cycle is performed for thirty minutes three times daily.

Daily warm tub baths are advocated. The tub bath is in at least twelve inches of lukewarm water and is followed by cocoa butter massage to both extremities. The massage is an up and down motion from the thighs to the toes.

OSTEOARTHRITIS IN INDUSTRY

Oswald Savage, O.B.E., M.R.C.P., Assistant Physician, British Red Cross Society's Clinic for Rheumatism, London; Chief Assistant, Rheumatism Department, West London Hospital; Deputy Medical Secretary, Empire Rheumatism Council. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE. Page 43, March-April, 1948.

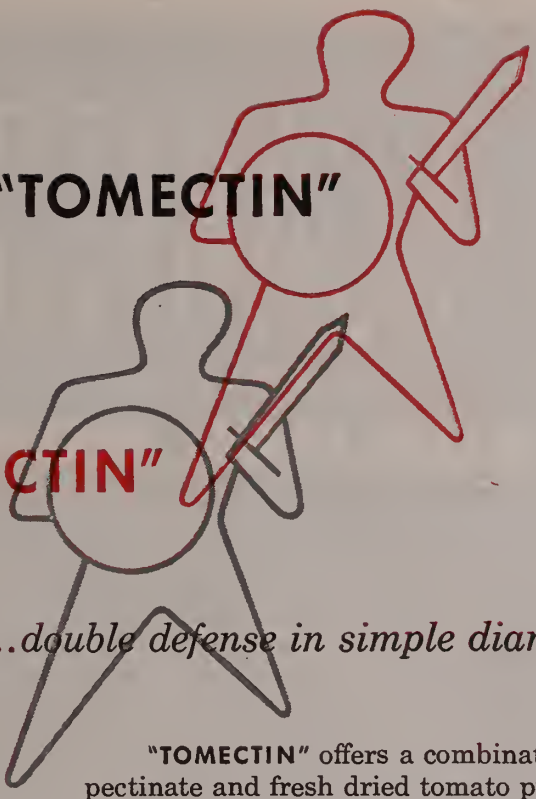
There is no chronic disease in which enthusiasm in the treatment of early symptoms pays so high a dividend.

The most important methods of treatment are heat to relieve the pain and exercises to strengthen the wasted muscles. These patients are usually strong and will tolerate strenuous treatment by exercises and rehabilitation.

There has been a tendency in the past either to dismiss these patients with a hopeless prognosis and allow them to take to their beds, when muscle atrophy is followed by crippledom, or for them to become chronic attenders at an outpatient physicial medicine department in the vain hope of restoring a damaged joint surface.

Both these courses are entirely wrong. Patients with osteoarthritis should be encouraged to keep at work, for by using their joints they will retain movement. Once the diagnosis is made it should

(*Continued on page* 44)



...double defense in simple diarrheas

"TOMECTIN" offers a combination of nickel pectinate and fresh dried tomato pulp—two therapeutic agents which have proved of value in the treatment of various diarrheal conditions, including bacillary dysentery.

WHY NICKLE PECTINATE? ...because its detoxifying and bacteriostatic effects as well as antihemorrhagic properties have proved clinically valuable in various diarrheal conditions.[1]

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Infants: 1 to 3 heaping teaspoonfuls every 3 hours or at each feeding. "Tomectin" may be readily dispersed in hot milk without causing the milk to curdle and, in this manner, may be incorporated in the infant's formula.

[1] Block, L. H., Tarnowski, A., and Green, B. L.: Am. J. Digest. Dis. *6*:96 (Apr.) 1939
[2] Morrison, L. M.: Am. J. Digest. Dis. *13*:196 (June) 1946



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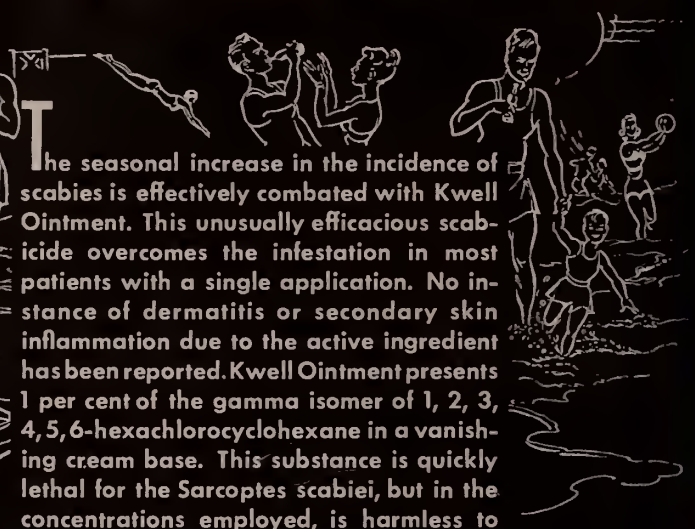
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be recognized that treatment for the relief of symptoms will be necessary and will have to be repeated, but this should be given in short courses which are stopped when symptoms are relieved. In this way such patients can be kept at work for many years, and if they will co-operate in keeping their affected muscles strong by exercises, the necessity for treatment will increase only very slowly.

In the prognosis of osteoarthritis clinicians should never become subservient to the radiologist.

TREATMENT OF PHLEBITIS AND ITS COMPLICATIONS

I. A. Bigger, M.D., Richmond, Virginia. In VIRGINIA MEDICAL MONTHLY, May, 1948, page 229.

Prophylaxis against clot formation in the veins should be discussed first. The most important prophylactic measure is the avoidance of prolonged bed rest. As you know, in most surgical clinics, this is being taken care of by early postoperative ambulation.

Elevation of the foot of the bed immediately after operation improves venous drainage and thereby helps avoid stasis. Leg exercises in those individuals who are not able to be out of bed avoids stasis and helps prevent clot formation. Anticoagulants, such as heparin and dicumarol, are of value but they have definite dangers and should not be used indiscriminately.

TREATMENT OF RHEUMATOID ARTHRITIS

W. S. Tegner, B. M. Oxfd, M.R.C.P., London, England. In THE LANCET XIII of Vol. I, 6500:469, March 27, 1948.

The treatment of rheumatoid arthritis can broadly be discussed under two heads: (1) general non-specific therapy to build up the general health, increase the weight, strengthen the muscles, prevent deformity, and maintain mobility: and (2) drugs aimed specifically at the disease process.

Local rest for the affected joints must also be prescribed. There is always the bogy of contracture, deformity, and crippling looming up in the vision of the rheumatoid arthritis. Deformity and crippling are the results of muscle spasm, and these spastic muscles must be relaxed and rested.

We are apt to disregard the lessons on body mechanics taught us by Goldwaite et al. (1941), who drew attention to the correct position-in which we should nurse our patients in bed, and the importance of permitting and encouraging adequate chest expansion.

The sitting position is dangerous in rheumatoid arthritis, and patients must be taught to keep their knee-joints extended rather than flexed.

Our most potent weapons against rheumatoid arthritis, then, are rest and non-specific physiotherapy. Some say that this is not treatment at all but merely palliation, and they would probably advocate specific treatment claimed to be directed against the cause of the disease.

INDICATION FOR SHOCK TREATMENT IN PSYCHIATRY

Trygve Braatoy, M.D., Oslo, Norway. In the AMERICAN JOURNAL OF PSYCHIATRY, 104, 9:573, March, 1948.

It is of interest in connection with the possibility of curing insomnia by electric shock treatment to consider whether such improvement in sleep can be thought to be due to lesions in the central nervous system. This possibility or risk in convulsion treatment has to be borne in mind from the very first, inasmuch as it was already known that epileptiform convulsions may be accompanied by cerebral changes of irreversible nature. This view was confirmed by anatomical examinations and had found expression in therapeutic practice, since the investigators of epilepsy believed that convulsions should as far as possible be avoided. The active students of the disease seem still to hold this opinion.

With respect to electric shock, which is perhaps the form now most employed, the results of the experimental investigations have been confirmed in clinical study by means of electroencephalography. It is found that after a couple of shocks the patients often show changes in their EEG corresponding to those which are otherwise usually ascribed to pathological affections of the cerebral cortex (W. Grey Walter, 1944 and L. C. Cook, 1944).

FUNCTION OF THE CRUCIATE LIGAMENTS OF THE KNEE-JOINT

Arthur J. Helfet, B.Sc., Cape Town, M.D., Ch. (Orth. Liverpool, F. R. C. S.). In THE LANCET, XVIII of Vol. I, 6505:665.

It is suggested that the cruciate ligaments act as guide ropes rather than check ropes. Rotation

(*Continued on page* 46)

immediate symptomatic relief of ocular allergies



ANTISTINE
OPHTHALMIC SOLUTION

THE ONLY ANTIHISTAMINIC EYE DROP NOW AVAILABLE, Antistine Ophthalmic Solution gives almost immediate symptomatic relief of ocular allergies in contrast to the less rapid action of oral antihistaminic therapy. One drop every 3 hours is usually sufficient. Available as 0.5% solution in 15 cc. bottles with dropper.

ANTISTINE IS ALSO AVAILABLE IN TABLET FORM for the systemic treatment of other general allergic symptoms. This new drug has been found effective in patients where another antihistaminic has failed or where side effects have necessitated discontinuation of therapy. Dosage is usually 3 to 4 tablets daily. Available as 100 mg. scored tablets.

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of the tibia on the femur is the movement controlled.

In the unstable knee the cruciate ligament and at the least part of the medial ligament are torn.

Loss of stability due to tears of these ligaments may be compensated by extra-articular tendon transpositions.

A dislocated "bucket-handle" cartilage prevents final "screwing-home of the knee-joint in extension, thus leaving the medial femoral condyle protruding over the line of the tibia when the knee is straight. This gives a simple and accurate clinical sign for the displaced cartilage.

THE EFFECTIVE TREATMENT OF LEG ULCERS IN PUERTO RICO

S. Arana-Soto, M.S., M.D., Chief, Rehabilitation Clinic, State Insurance Fund, San Juan, Puerto Rico.
In INDUSTRIAL MEDICINE. Volume 17, No. 4. Page 121, April, 1948.

We want to report on the successful treatment of leg ulcers. Our cases represent a very good cross-section of such cases in this Island, for we are the only one to give special attention to peripheral vascular diseases in Porto Rico and the patients come from every part of the country, both from urban and rural districts.

Physical therapy, except bandage which is a physical measure, was never found to be necessary. Copper ion Transfer, diathermy, rhythmic constriction, heat or U. V. were not used. And this in spite of the fact that we do physical therapy and have complete equipment and personnel. On the other hand, our impression is that U. V. should be given a good trial in such ulcers, as do not heal by the method here described. The application of a rubber sponge, as described by Ochsner and Mahorner in their book, is decidedly beneficial in a certain number of cases.

WHAT CAN WE EXPECT FROM ELECTRO-SLEEP (ELECTRO-SHOCK) TREATMENT

C. S. Holvrook, M.D., New Orleans, Louisiana.
Southern MEDICAL JOURNAL, 41, 5:444, May, 1948.

In an attempt to answer this question, in part at least, a study has been made of 200 depressed patients who were treated between 1935 and 1940 in the DePaul Sanitarium and another group of like size who were treated in the same hospital with electro-sleep (electro-shock) therapy in the years 1942 to 1947. These patients were discharged as "improved," "cured," or "restored," the different terms frequently having the same meaning but employed by different psychiatrists. Patients who were in the sanitarium less than two weeks, those withdrawn or transferred to another hospital, those who died, or those who remained for further treatment were not considered. The study is of 400 discharged patients, 200 before the use of electro-sleep (electro-shock) therapy and 200 who received an average of 10.26 electric treatments. The study included also 200 manic patients (probably nearly all belonged to the manic depressive group), 100 patients who were treated before electro-sleep (electro-shock) therapy and 100 who received an average of 11.55 electric treatments.

FRACTURES OF THE TIBIAL CONDYLES INVOLVING THE KNEE JOINT

Edwin F. Cave. In SURG., GYNEC, & OBSTET 86:289 (March) 1948.

Whether plaster immobilization or suspension in a hinged splint should be used after operation is optional. It is believed that if the fracture or fractures have been well stabilized by the bolt, suspension is sufficient. Early exercises can be carried out in the splint and at the end of a six weeks' period, the patient is allowed up on crutches, and with little weight-bearing in a light hinged brace to prevent any tendency to valgus deformity of the knee.

If the fracture is a simple, not a comminuted one, it is possible that manipulation and compression, followed by plaster, will be sufficient. For the minor displacements, manipulation and plaster fixation may improve the situation. As in all fractures of weight-bearing joints, delayed weight-bearing must be practiced. Crutches must be used for a period of two to six months, depending on the severity of the injury. Any tendency to valgus position of the knee must be prevented by the use of a hinged brace and Thomas heel.

Although roentgenograms play an all-important role in objectively discovering and delineating tuberculous lesions, they will never be accurate enough to supplant sound medical judgment. R. V. Platou, M.D., Am. Rev. Tbc., April 1947.



HAY FEVER *relief* day and night...

The extra long action of Neo-Synephrine hydrochloride makes possible control of hay fever symptoms with infrequent dosage, thus enabling the patient to be comfortable during the day and obtain sleep at night.

Average dose: 2 or 3 drops in each nostril.

No appreciable interference with ciliary action. Virtually no side reactions.

FOR NASAL USE: ¼% solution (plain and aromatic), 1 oz. bottles; 1% solution, 1 oz. bottles; ½% water soluble jelly, ⅝ oz. tubes.

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LIVING COSTS RISE FASTER THAN PHYSICIANS' FEES

The cost of living has risen more rapidly than the fees charged by physicians for medical services, according to Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the American Medical Association.

In his new study entitled "Comparative Increases in the Costs of Medical Care and the Costs of Living," Dr. Dickinson stated that the quantity of medical care received by the American people was at least two thirds more in 1946 than in 1939.

"When the various indexes and ratios are studied," Dr. Dickinson said, "it can be seen that the quantity of medical care received by the American people has probably increased much faster than the increase in the number of physicians. This apparent 'output' per physicians doubtless reflects the increasing use of technical assistants.

"Whether one examines the record of total expenditures of the American people for medical care or the prices of significant items during recent years, he comes to the general conclusion that the American people have been fortunate in that the costs of keeping well have not risen as rapidly as the cost of living."

In his new study, just off the press, Dr. Dickinson made extensive use of the price indexes compiled by the U. S. Bureau of Labor Statistics. A four page bulletin contains figures and charts supporting his conclusions.

The Bureau of Labor Statistics index, covering cost of living in 34 cities, was 59 per cent higher in 1947 than in the base period of 1935-39.

The Bureau's 1947 index for all medical care, including drugs, was only 32 per cent above the 1935-39 period. Excluding drugs, the increase was 35 per cent and for drugs only the increase 15 per cent.

"This doesn't reflect the quantity of medical care," Dr. Dickinson said, explaining that the 1946 index of personal consumer expenditures for medical care was 211, or 111 per cent above the 1935-39 base period.

"A statistician," he explained "arrives at the index of quantity of medical care by dividing the index of expenditures by the index of prices of medical care." Thus, he established that the

(*Continued on page* 50)

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Illinois State Medical Society,
Monmouth, Illinois.

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My check is enclosed in the above amount.

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Make checks payable to: COMMITTEE ON MEDICAL BENEVOLENCE.

MEAT

And the Dietary of Pregnancy and Lactation

According to a study published in the recent past[1] it has been shown that nitrogen balance is suddenly reversed from positive to negative shortly before term. This negative balance is further intensified by substantial losses of nitrogen during parturition and the postpartum period. Lactation imposes still another burden on nitrogen metabolism.

This study again emphasizes the need for a diet rich in biologically complete protein during the latter half of pregnancy. In this manner, the physiologic loss of nitrogen at term can be compensated, avoiding negative nitrogen balance. A high protein diet has the further advantage of producing a more copious milk supply.

In another recent publication,[2] the prevention of the toxemias of pregnancy by dietary means was stressed. Foremost among the measures recommended was a diet rich in high quality protein to assure nitrogen balance.

Meat is an outstanding source of protein in the dietary of pregnancy and lactation for these four reasons: (1) It is notably rich in protein, from 17 to 20 per cent of its uncooked, and from 25 to 30 per cent of its cooked weight; (2) The protein of meat, regardless of cut or kind, is biologically complete; (3) The appetite appeal of meat is high, and (4) All meat is of excellent digestibility—from 96 to 98 per cent.

[1] Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

[2] Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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American Meat Institute

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Living Costs (Continued)

index of expenditures for 1946, 211, was more than two thirds higher than the index of prices of medical care, 122.

He used the index of personal consumer expenditures for all medical care items as provided by the U. S. Department of Commerce.

Dr. Dickinson estimated that the quantity of physicians' services—one of the medical care item —was approximately one-half greater in 1946 than in the base period 1935-39, but the number of physicians was only one-seventh greater.

Dr. Dickinson's newest study is the second made within a year. In 1947, he published a study entitled "Is Medical Care Expensive?" In this 12-page pamphlet, Dr. Dickinson said that medical care items as a whole cost the American people $5,600,000,000 in 1946, but that only 3.9 per cent of the total personal consumer expenditures of the American people were spent for these medical care items. This compared with 4.3 per cent in 1940.

He also found in his first study that in 1946 physicians received only 26 per cent of all dollars spent for medical care as compared with 31 per cent in the base period, 1935-39, and 32 per cent in 1929, the first year for which the data were gathered and published by the U. S. Department of Commerce. On the other hand, he found that the amount spent for drugs in 1946 had risen to 24 per cent of all dollars spent for medical care as compared with only 21 per cent in the base period, 1935-39, and 20 per cent in 1929.

General hospitals should admit all contagious diseases that need hospital care. This would eliminate expensive contagious disease hospitals that are practically empty half the time. Tuberculosis is becoming more and more a responsibility of the general hospital as the disease is detected earlier and treatment is much the same as for any other acute illness. Graham L. Davis, Bull. Am. Coll. Surgeons, Jan., 1948.

Periodic group chest X-rays are of value to industry through the detection of early cases of tuberculosis, whereupon a leave of absence for treatment, followed by assignment to duties with less exacting physical demands can be arranged. Also, the chest survey may give the first indication of progressive heart disease and be the clue leading to the removal of a man from arduous physical work. Rodney R. Beard, M.D., Nat. Tuberc. A. Tr., 1947.



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A small suction pump with a spring-returned plunger and clear plastic suction cup, the Petechiometer applies negative pressure to a hairless area of skin two centimeters in diameter. A magnifying glass blown into the upper surface of the cup helps count petechiae which develop.

The air is expelled from the suction cup by pressure of thumb on plunger. The cup is then placed lightly but firmly upon the skin. As thumb pressure is released, spring action applies suction. After one minute, suction is released; after five minutes, petechiae are counted. By moving an adjustable "stop" ring the test may be repeated at two additional suction levels. Remember that increased capillary fragility is a complication of many clinical conditions.

You can obtain the Petechiometer only at drug stores displaying the familiar blue and white Rexall sign—your assurance of drugs manufactured under rigid laboratory control, compounded with superior pharmacal skill. Your Rexall druggist will be glad to tell you more about the Petechiometer. Or write to Rexall Drug Company, Los Angeles, California.

**Petechiometer is a registered trade-mark owned by the Rexall Drug Company covering a clinical device for the measurement of capillary fragility.*

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BOOK REVIEWS



OPHTHALMOLOGY IN THE WAR YEARS. Vol. 1 (1940-1943). Edited by Meyer Wiener, M.D. Clothbound, 1,166 pages, references, subject index, and author's index. Chicago, 304 South Dearborn Street, Year Book Publishers, Inc., 1946. Price, $13.50.

Almost an Index Medicus in Ophthalmology, this monumental work would serve as a reference of the literature in ophthalomology published in the Western Hemisphere during the War Years 1940-1943.

My personal contacts with the Editor-in-Chief has convinced me through the years that Meyer Wiener always does a good job. In this endeavor he has not failed. He has surrounded himself with a corps of experts and apparently it was he who so ably assigned them to the individual subjects for review and a running comment of the articles published in the literature.

The work is voluminous and justly so. Otherwise it would not be of the great value it is and will prove to be. It is difficult to select the high spots. "Surgery by Alvis" is excellent, as is "Muscles by Guibor." "Neuro-Ophthalmology" by Leinfelder is good and thorough as is the chapter on "Therapeutics by Cordes and Aiken." In fact while those mentioned seem especially interesting to the reviewer all of the subjects are thoroughly covered and represent a tremendous number of hours of "overtime."

The index is complete and the meticulous manner in which the Editor-in-Chief has always done everything is undoubtedly responsible for this feature and, in the reviewer's opinion, one of the most important features of any book.

The book is not only valuable because of the abstracts of literature but because it also contains many of the expert opinions of those who reviewed the various subjects.

The profession is to be congratulated that so many ophthalmologists were willing to associate themselves in this "labor of love." This is a valuable book that will endure. We will be anticipating the second volume.

W.D.S.

THE OCULATORY MUSCLES by Richard G. Scobee, B.A., M.D. Instructor in Ophthalmology, Washington University School of Medicine, St. Louis, Mo. Illustrated. St. Louis: The C. V. Mosby Company, 1947. Price $8.00.

The Oculorotary Muscles, their functions and dysfunctions, are treated in a most interesting and relatively easily understandable manner by Doctor Scobee. It is obvious that the author has thoroughly enjoyed the preparation of this fascinating treatise on one of the most intriguing fields in ophthalmology.

The book is for ophthalmologists. It was born in the graduate student lecture room, reared among graduate students, and has come of age in 359 pages of ocular deviation background, symptoms, diagnosis and treatment.

Recognized authorities are frequently quoted verbatim with proper credit. Many of the author's original views are expressed and in the instances where they are in conflict with present teachings, appropriate supportive discussion is presented. References are found at the end of the chapters and include outstanding writers from Donders in 1847 to Fink and others in 1947.

Most textbooks mention eight cardinal directions of gaze. Doctor Scobee emphatically declares that there are only six pairs of oculorotary muscles and therefore only six cardinal directions of gaze.

Rules to clarify the mysteries of the yokes, the antagonists and the synergists are simply stated and an

(*Continued on page* 54)

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Book Reviews (Continued)

admonition given that it is a waste of time to memorize large numbers of possibilities which never occur.

It is believed that Doctor Scobee has attained his sincere hope "for a simple but accurate and workable approach to the subject of the oculorotary muscles and their dysfunction".

L. P. A. S.

SYNOPSIS OF OBSTETRICS: By Jennings C. Litzenberg, B.Sc., M.D., F.A.C.S., Professor Emeritus of Obstetrics and Gynecology, University of Minnesota Medical School, Minneapolis. With 157 illustrations including 5 in color. Third Edition. St. Louis; The C. V. Mosby Company, 1947. Price $5.50. 416 pages.

Synopsis of Obstetrics is one of a number of such synopses on various medical specialties. These books have met with general acceptance and this particular book has been published in its third edition. This book is not a text-book, but it serves well the purpose of systematizing the important practical aspects of obstetrics, which should be of particular value to the student. The following subjects have been completely re-written: the diagnosis of pregnancy with special reference to reliable laboratory tests; relief of labor pain; diabetes in pregnancy, and the effect of pregnancy on diabetes; the treatment of puerperal infections with the sulfonamides and penicillin; and the Rh factors in pregnancy. There are 157 informative illustrations, including a few drawings and photographs, and a few microscopic illustrations. A book of this type is a worthwhile addition to a medical library.

J. W. F.

SYNOPSIS OF NEUROPSYCHIATRY: by Lowell S. Selling, M.D., Ph.D., Dr. P.H., F.A.C.P., Director, Division of Mental Health, Florida Department of Health; Formerly, Attending Neuropsychiatrist, Deaconess Hospital; Associate Attending Neuropsychiatrist, Mt. Carmel Mercy Hospital, and Wayne County General Hospital; Director, Psycopathic Clinic, Recorder's Court, Detroit, Michigan; Assistant Professor of Criminology, Medical Jurisprudence and Social Hygiene, University of Illinois College of Medicine; Lecturer in Psychology, Wayne University; Visiting Professor of Psychology, Iowa State College. Illustrated. Second Edition. St. Louis, The C. V. Mosby Company, 1947. Price $6.50. Pages 561.

The second edition of Synopsis of Neuropsychiatry is quite a complete presentation of basic neuropsychiatric facts which one must possess to understand the general field of this subject. The material is well written in a systematic manner which enables the reader to organize the basic principles. The practical aspect is emphasized and the irrelevant material is evaluated. As to doctrine, the author takes a middle-ground viewpoint. The book is composed of two parts: anatomy and anatomical disorders; and mental

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J. W. F.

A CORRECTION

In our March issue, our book review of Gifford's "Ophthalmology" listed the publisher as Lea and Febiger. This is incorrect. The publisher of this excellent textbook is W. B. Saunders Company of Philadelphia.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

TREATMENT OF HEART DISEASE: By William A. Brams, B.S., M.D., Ph.D., Associate Professor of Medicine, Northwestern University Medical School, and Attending Physician, Michael Reese Hospital, Chicago. Illustrated. Philadelphia and London, W. B. Saunders Company, 1948. Price $3.50.

(*Continued on page* 57)



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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CLASSIFIED

Classified Advertisements 62

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American Meat Institute, Chicago 49
Borden Company, 350 Madison Ave., New York 10
Coca Cola, Atlanta, Ga.
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover
National Confectioner's Assn., Chicago 2 36
Wander Company, 360 N. Michigan Ave., Chicago 24

FINANCIAL AND INSURANCE

Medical Protective Co., Fort Wayne, Ind. 6
Physician Casualty Co., Omaha, Neb. 61

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 8
Ames Co., Inc., Elkhart, Ind. 55
The Arlington Chemical Co., Yonkers, N. Y. 5
Armour Laboratories, Chicago 9, Ill.
Ayerst, McKenna & Harrison Ltd., New York 16 41
Barlow-Maney Laboratories, Inc., Cedar Rapids, Iowa .. 12
Bilhuber Knoll Corp., Orange, N. J. 54
Borcherdt Malt Extract Co., Chicago 12, Ill. 62
Bristol Laboratories, Inc., Syracuse 1, N. Y. 7, 32
Bristol-Meyers Co., New York 38
Ciba Company, Summit, N. J. 30, 45
Commercial Solvents Corp., Terre Haute, Ind. 42
Doho Chemical Corp., New York 13, N. Y. 22
C. B. Fleet Co., Inc., Lynchburg, Va. 15
Gold Pharmacal Co., New York 61
Hoffman-LaRoche, Inc., Nutley, N. J. 11
Holland-Rantos Co., Inc., 551 Fifth Ave., New York .. 43
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 50
Interchemical Corp., Union, N. J. 26
International Pharmaceutical Corp., Boston 16
International Vitamin Corp., 50 E. 42nd St., New York City
Irwin, Neisler & Co., Decatur, Ill.
Lanteen Medical Laboratories, Chicago 10 14
Lily, Eli & Co., Indianapolis, Ind. 33, 34, 35
S. E. Massengill Co., Bristol, Tenn.
Merck & Co., Rahway, N. J. 17
Morris, Philip & Co., 119 Fifth Ave., New York
Nepera Chemical, Yonkers, N. Y.
Num Specialty Co., Pittsburgh, Pa. 59
Parke, Davis & Co., Detroit, Mich. 23
Plastishield, Inc., Minneapolis
Reed & Carnrick, Jersey City 6, N. J.
Rexall Drug Co., Los Angeles 51
Reynolds & Co., R. J., Winston-Salem, N. C. 21
Roche-Organon, Inc., Nutley, N. J. 29
J. B. Roerig & Co., 536 Lake Shore Drive, Chicago
Sandoz Pharmaceuticals, New York 14
Schenley Laboratories, Inc., N. Y. 1, N. Y. 18
Schering Corp., Bloomfield, N. J. 3, 37
Schmid, Julius, Inc., 423 W. 55th St., New York City ..
G. D. Searle & Co., P. O. Box 5100, Chicago
..... Inside Front Cover
Sharp & Dohme, 11 Canal St., Chicago 25
Smith, Kline & French, Philadelphia 9, 28, 39, 53
E. R. Squibb & Co. 4
The Tarbonis Co., Cleveland 3, Ohio
Upjohn Co., Kalamazoo, Mich.
U. S. Vitamin Corp., New York 17 19, 20
Walker Vitamin Products, Inc., New York
Wm. R. Warner & Co., 113 W. 18th St., New York 16
Whittaker Laboratories, Inc., New York City 31
White Laboratories, Inc.
Winthrop Stearns Co., 70 Varick St., New York .. 27, 47
Wyeth Incorporated 13
Zemmer Co., Pittsburgh, Pa. 62

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 57
Costeff Sanatorium, Peoria, Ill. 60
Douglas Park Hospital, Chicago 23 57
Edward Sanatorium, Naperville, Ill. 58
Michell Farm, Peoria 58
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 59
North Shore Health Resort, Winnetka 60
Mary Pogue School, Wheaton, Ill. 61
Stokes Sanitarium, Louisville, Ky. 62

SCHOOLS

Washington University, St. Louis 10 52

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Central X-Ray & Clinical Laboratory, 58 E. Washington, Chicago 59

Books Received (Continued)

A History Of The Heart And The Circulation: By Frederick A. Willius, M.D., M.S., in Medicine, Senior Consultant in Cardiology, Mayo Clinic; Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; and Thomas J. Dry, M.A., M. B., CH. B., M. S., in Medicine, Consultant, Section on Cardiology, Mayo Clinic; Associate Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. 456 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1948. Price $8.00.

Modern Clinical Psychiatry: By Arthur P. Noyes, M. D., Superintendent, Norristown State Hospital, Norristown, Penna. Third Edition. 525 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.00.

War, Politics, And Insanity: By C. S. Bluemel, M. A., M. D., F. A. C. P., M. R. C. S. (Eng.). The World Press, Inc., Denver, Colorado, 1948. Price $2.00.

A Negro Nation: By Bernard S. Maloy, M. D., Boston: Champman & Grimes, Publishers. Price $1.25.

HEALTH OF PRESCHOOL CHILDREN

The striking decline in the mortality among children of preschool age is an outstanding example of the recent progress in American public health. In the comparatively short period from 1930 to 1946, the death rate dropped more than 60 per cent among boys and girls 1 to 4 years of age insured in the Industrial Department of the Company (Weekly Premium Branch). For some of the individual causes of death, the reduction has been unbelievably large. The death rate from diarrhea and enteritis, for example, declined fully 90 per cent between 1930 and 1946, the mortality from the principal communicable diseases of childhood dropped virtually 80 per cent, and the rate from pneumonia nearly 75 per cent. In fact, almost all the major causes of death at ages 1 to 4 recorded large reductions. Accidents are the exception, the death rate from this cause declining 9 per cent among the boys and 19 per cent among the girls in the period under study. Pneumonia, which in 1930 was the leading cause of death by a very considerable margin, is now a poor second to accidents. Diarrhea and enteritis no longer rank among the leading causes of death at the preschool ages. A surprising development is the entry of cancer (including leukemia) in the picture as a leading cause of death, now ranking fifth among boys and fourth among girls at the preschool ages. This cause currently is responsible for one death in every 19 among children 1 to 4 years in this insurance experience.—*Statistical Bulletin*, Metropolitan Life Insurance Company, March, 1948.

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PRECAUTIONARY MEASURES SET UP FOR EPIDEMICS OF RINGWORM OF SCALP

Public health measures designed to prevent another epidemic of ringworm of the scalp among children have been drawn up by a group of New York dermatologists, according to an article appearing in the current issue of the Archives of Dermatology and Syphiology.

Ringworm of the scalp, which was one of the physician's main problems during the war years, is a fungus growth. It develops one or more circular patches of redness and crust formation. The hairs in the affected region become loose and break off just above the skin surface, leaving short stumps. The main reason for its spread is attributed by the authors, Drs. Frank C. Combes and Howard T. Behrman, New York, to lack of parental observation and control, and cleanliness.

"It is a great tribute to American medicine," the doctors write, "that recognition of the severity, contagion and extent of the disease brought forth speedy measures of isolation, control and treatment. Treatment centers were established in strategic areas throughout the country.

"Various new drugs have been employed with success in certain types of ringworm of the scalp, but the major weapon of control in the so-called 'human' type is x-ray treatment.

"In a certain percentage of cases, reinfection (from contaminated hats, articles of clothing, other children or infected members of the same family) may occur. Following x-ray treatment all infected articles of clothing should be burned."

The New York group has outlined the following set of measures designed to control subsequent epidemics of ringworm of the scalp:

1. Ringworm of the scalp should be made a reportable disease.

2. The public should be reached through the press, pamphlets and radio.

3. It is recommended that city-wide, complete and periodic inspection of children who are in institutions be made by qualified physicians.

4. Barbers should be told about epidemics and cautioned to be on the lookout for sores on the scalp.

5. Children should wear hats as a precaution against infection in public places.

6. Clipping and shaving of the hair prior to x-ray treatment should be done in the clinics at which infected children are treated. The parents should be warned not to take an infected child to a barber.

7. The department of health should register equipped clinics and qualified physicians for the treatment of ringworm of the scalp.

8. It is recommended that no child be permitted to return to school until he is entirely free from infection.

Nebraska State Medical Journal, June, 1948.

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PENICILLIN NOT PROVED BEST FOR BABY'S EYES, MEDICAL JOURNAL HOLDS

Penicillin has not yet been shown to be superior to nitrate of silver for use in the eyes of the newborn as a guard against infection and its use without further experience would be a "calamity," the New York State Journal of Medicine asserts in an editorial in a recent issue. The publication is the official organ of the Medical Society of the State of New York.

An article in a recent issue of a popular woman's magazine (Woman's Home Companion, April 1948) claimed that babies are often rendered blind by the use of nitrate of silver as a prophylactic because the law in many states compels its employment by physicians. This disaster, according to the article, could be avoided by substituting penicillin for nitrate of silver.

"This is by no means proved," the Journal editorial comments, "and it would, in our belief, be a calamity if a tried and certain method were discarded without further experience with another which has by no means been shown to be superior. Perhaps there is a substitute which causes less reaction than silver nitrate, but we had better know more about that before the claim of infallibility is disseminated."

A world wide acceptance of the use of a dilute solution of silver nitrate following the introduction of this method to prevent gonorrheal infection in the newborn by Crede, German gynecologist, the editorial points out. It acknowledges that some failure is possible, due to carelessness or forgetfulness or improper application by the attendant at childbirth. The sanitary codes of most American states and cities require the prophylactic instillation of silver nitrate or, as in the case of New York City, "an equally effective agent."

The Journal editorial points out that a special committee of the New York Academy of Medicine, named in response to a request from the New York City Commissioner of Health for an opinion as to the desirability of changing the Sanitary Code to accept penicillin as a substitute, did not recommend any change, although it did suggest that hospitals, under adequate control, be encouraged to make further studies.

"The Special Committee of the Academy considering the problem," the Journal states, "includes in its personnel an ophthalmologist, a pediatrician and an obstetrician. Their opinion that the use of silver nitrate should be continued, pending the further study of the value of and practical considerations relating to the use of penicillin, preserves a tried and proved remedy in the use of which professional personnel have been trained over a long period of time."

"Mention must be made of the fact that ophthal-

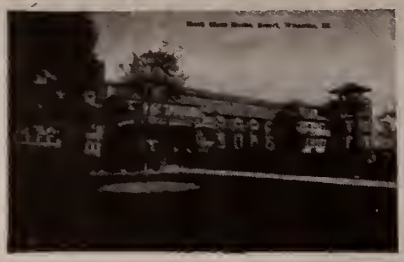
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Baby's Eyes (Continued)

mia in infants is not necessarily gonorrheal," the Journal comments. "There may be other organisms involved—streptococci, staphylococci, pneumococci, coliform organisms, and viruses. Many of these are strains resistant to penicillin. Proof of the effectiveness of the latter does not, up to the present, appear adequate. Moreover, the most effective concentrations and the best method of application have yet to be determined. Solutions must be fresh, and several instillations are required. In unskilled hands it may not be so simple as a single instillation of silver nitrate for prophylactic administration."

The records in the chest diagnostic clinics prove that the physicians of the state, if they are determined to do so, can perform a better job of suspecting and discovering active tuberculosis cases, year in and year out, than any other agency. It is noteworthy that in the past year, as in other years, more cases of active pulmonary tuberculosis were found among the referrals by physicians to the chest diagnostic clinics than in any other groups of people examined. Comm. on Tbc., N. H. Med. Soc., New England J. Med., Oct. 23, 1947.

NAVY HOSPITAL CORPS CELEBRATED 50TH ANNIVERSARY

On June 17, 1948, the Navy Hospital Corps celebrated its 50th Anniversary. Organized during the Spanish-American War, the Hospital Corps has since flourished, and its importance to the Navy can only be measured by the thousands of lives saved in both war and peace by these intrepid men.

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the officers of the Hospital Corps have worked their way up through the ranks. These men now hold important administrative positions in Naval hospitals and on board hospital ships throughout the world, thereby releasing doctors to medical work.

Hospital Corpsmen saved countless lives during the last war by their courage in the jungles and at sea, and by their magnificent operations in the air evacuation of all types of casualties from island beachheads. The toll was great; on Iwo Jima the death rate of Hospital Corpsmen was even higher than that of the Marines.

Through its half century of ministering to the Navy's ill, in peace and in war, the Hospital Corps has earned the respect of all who have served in the Navy and Marines. Many former members of the Corps have gone on to become doctors in civilian life. These men look back on their Hospital Corps training as immeasureable in value.

Even if not more than two-thirds of the cases of erythema nodosum are associated with a tuberculous primary infection, it is obvious that every tuberculin-positive case must be treated in private practice as a possible expression of tuberculosis until thorough examination has shown that this possibility can be ruled out. The best guide to the aetiological diagnosis seems to be the vesicular tuberculin reaction. Hans Jacob Ustvedt, M.D., Tubercle, Dec., 1947.

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NURSES HANDLING STREPTOMYCIN MAY DEVELOP SENSITIVITY TO DRUG

Nurses, pharmacists, laboratory technicians and others concerned with the administration or handling of streptomycin are in danger of developing a sensitivity to the drug, three doctors state in the February 28 issue of The Journal of the American Medical Association.

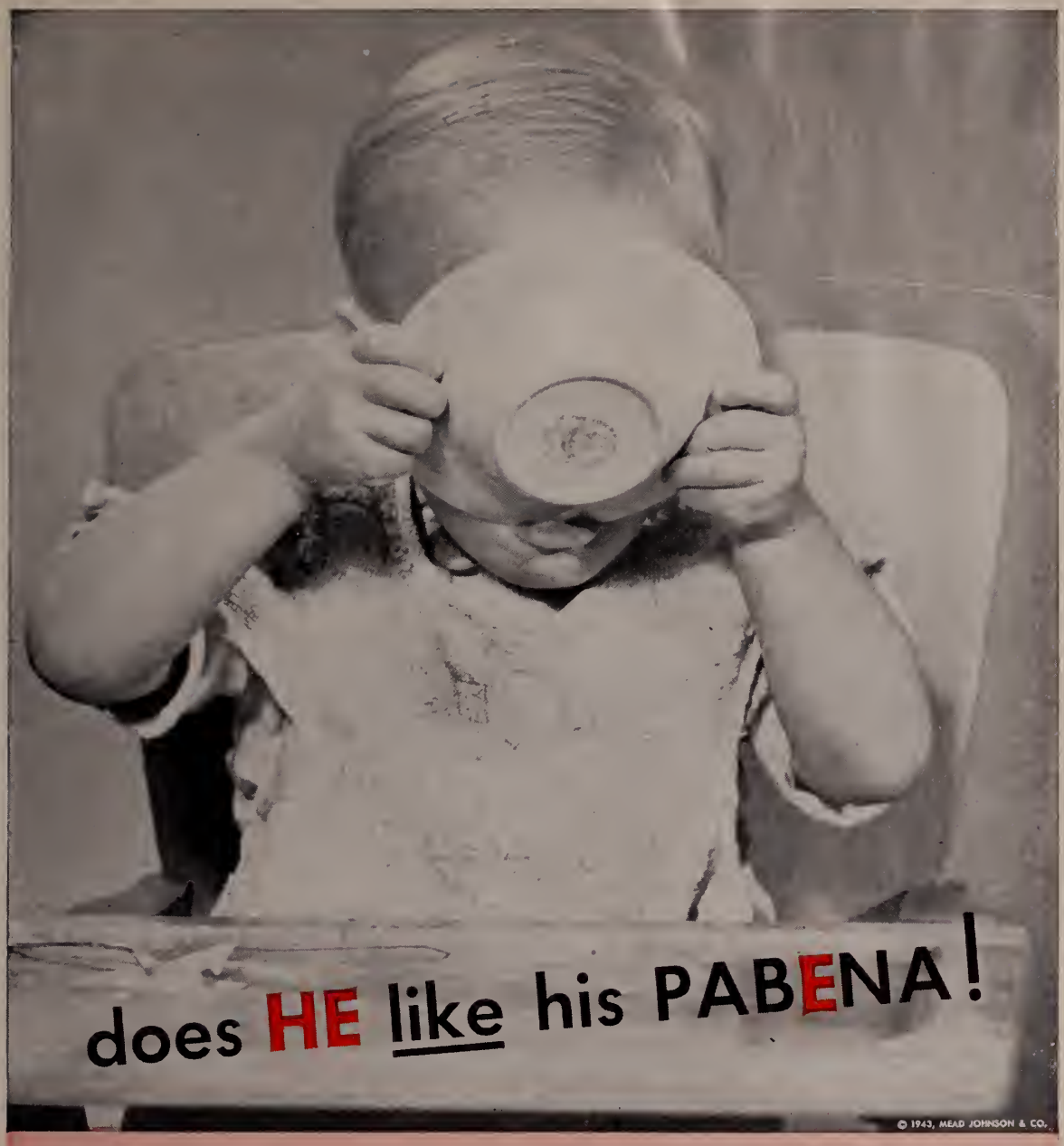
The writers are Soloman M. Rauchwerger, M.D., Frederick A. Erskine, M.D., and Walter L. Nalls, M.D., from the Department of Medicine and Surgery, Veterans Administration, Oteen, N. C. They report that when over a period of twenty months streptomycin was administered to 233 patients in the tuberculosis hospital at Oteen, N. C., six nurses developed such a sensitivity. In every case the first symptom was a rash on the hands, followed by intense itching. Five of the six nurses also showed involvement of the area around the eye socket. Pyribenzamine proved more effective than benadryl for relief of symptoms.

Flies may not be responsible for poliomyelitis outbreaks. An epidemic occurred in a clean, sanitary area in Caldwell, Idaho, after use of DDT had repeatedly rid the town of flies and other insects. Among the population of 8,700 persons, fifty-two had infantile paralysis and two died.

Rocky Mountain Medical Journal, May, 1948

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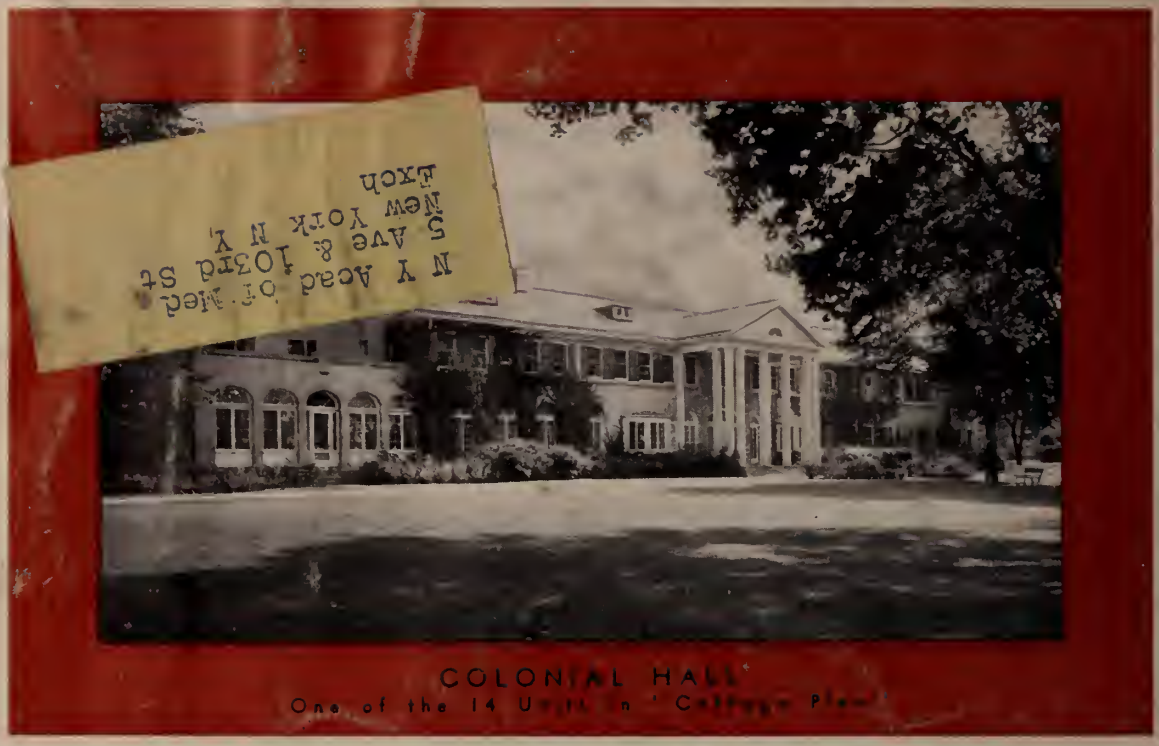
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The ILLINOIS Medical Journal

VOL. 94 NO. 2

August, 1948

Problems of Medical Care in the Atomic Age

The Clinical Application of the RH Factor

Pictures of the Annual Meeting

(See page 5 for complete Table of Contents)

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

Report of the Committee on Therapy of

THE AMERICAN ACADEMY OF ALLERGY

on HYDRYLLIN

The results of the study:

		60% to 100% EFFECTIVE (*Regarded as "Good"*)	40% to 60% EFFECTIVE (*Regarded as "Fair"*)	0% to 40% EFFECTIVE (*Regarded as "Poor"*)
Hay Fever	790 CASES	304 (38%)	234 (30%)	252 (32%)
Asthma	397 CASES	119 (30%)	82 (21%)	196 (49%)
Pollen Asthma	226 CASES	73 (32%)	55 (24%)	98 (44%)
Vasomotor Rhinitis	130 CASES	20 (16%)	42 (32%)	68 (52%)
Urticaria	24 CASES	4 (17%)	8 (33%)	12 (50%)
Eczema	3 CASES			3
TOTAL	1,570 CASES			

Side Reactions

No Reactions 1,219 Cases (72%)
Moderate Reactions . . . 314 Cases (20%)
Severe Reactions 126 Cases (8%)

Conclusion: From these figures it would seem that the preparation has a fair degree of effectiveness in hay fever. In the asthmatic cases, both those with asthma due to pollen and those having asthma from other sources, the figures of the effectiveness of the drug are more impressive than those of other antihistaminics

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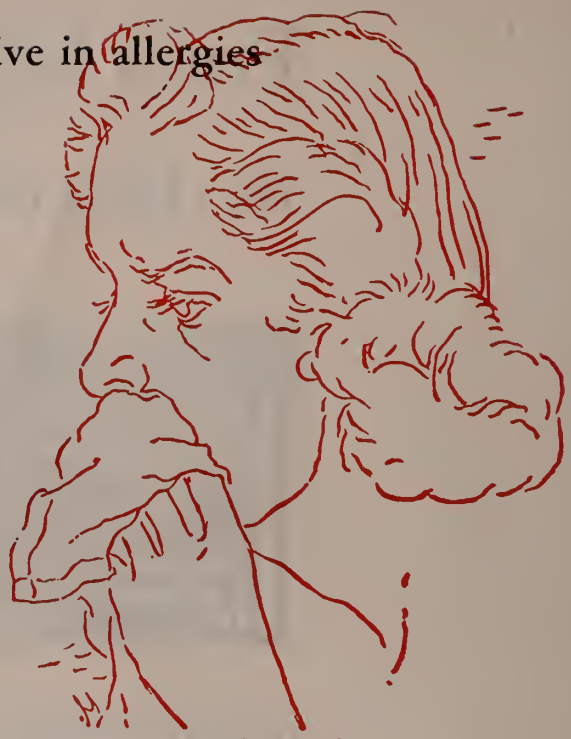
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1. FRIEDLAENDER and FRIEDLAENDER: *Ann. of Allergy*, 6: 23, 1948.

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TABLE OF CONTENTS

AUGUST, 1948
Vol 94, No. 2

PICTORIAL REPORT ON THE 1948 ANNUAL MEETING 113

HOUSE OF DELEGATES
Second Session, May 12, 1948 121

ORIGINAL ARTICLES
Problems of Medical Care in the Atomic Age, *Harold C. Lueth, M.D.*, Dean, University of Nebraska College of Medicine, Omaha 93
The Clinical Application of the RH Factor, *E. T. McEnery, M.D., G. R. Baba, M.D.*, and *K. Togasaki, M.D.*, Chicago 99
Conservative Obstetrics, *Ernest E. Davis, M.D.*, Avon 103
Phenylpyruvic Oligophrenia, *Herman Josephy, M.D.*, Chicago 107
Subacute Baterial Endocarditis Treated with Streptomycin, Case Report, *Julius N. Bell, M.D.*, Kewanee 119

EDITORIALS
The 1948 Annual Meeting of the American Medical Association 81
Dr. Isaac A. Abt Received Distinguished Service Award 82
The Physician and Veteran Groups, *Col. Paul G. Armstrong* 83
Book Reviews 50

STATE DEPARTMENT OF PUBLIC HEALTH
Hospital Survey and Construction Plan in Illinois Gets Under Way 84

MEDICAL ECONOMICS
Vacations 89

CORRESPONDENCE
Orientation Course in Allergy at N. U. 91
The American Congress of Physical Medicine 91
Saunders Appointed Associate Director 91
Obstetricians will Meet in Denver 92
Mississippi Valley Medical Society Meeting at Springfield 92
A. C. S. Clinical Congress to be in Los Angeles .. 92

PHYSICAL MEDICINE ABSTRACTS 40

NEWS OF THE STATE 137

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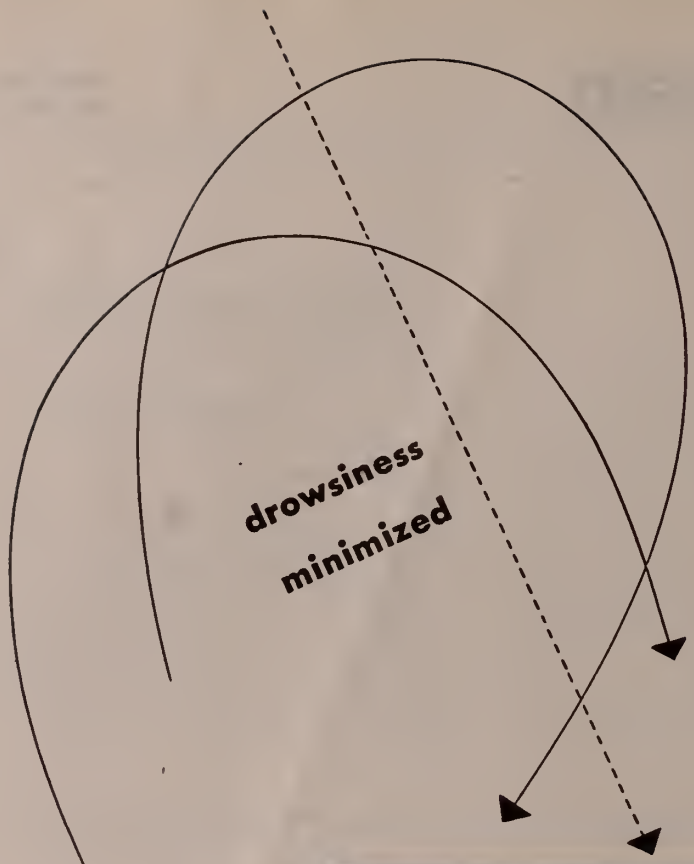
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Union	A. L. Ashworth, Cobden	E. V. Hale, Anna.
Vermilion	A. R. Brandenberger, Danville	E. T. Baumgart, Danville.
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Warren	J. W. Firoved, Monmouth	Jos. C. Sherrick, Monmouth.
Washington	P. B. Rabenneck, Nashville	Roscoe C. Vernor, Nashville.
Wayne	Leslie W. Young, Fairfield	Kenneth O. Hubble, Fairfield.
White	C. J. Rosenberg, Norris City	R. S. Loewenherz, Carmi.
Whiteside	Neal J. Marquis, Sterling	G. J. Pohly, Rock Falls.
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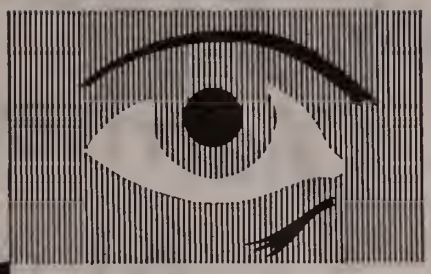
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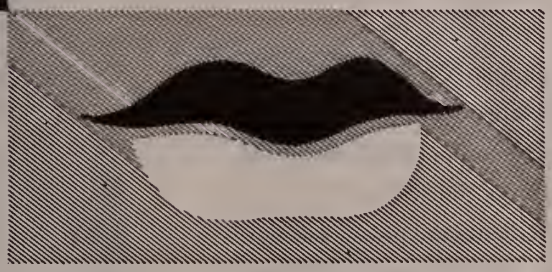
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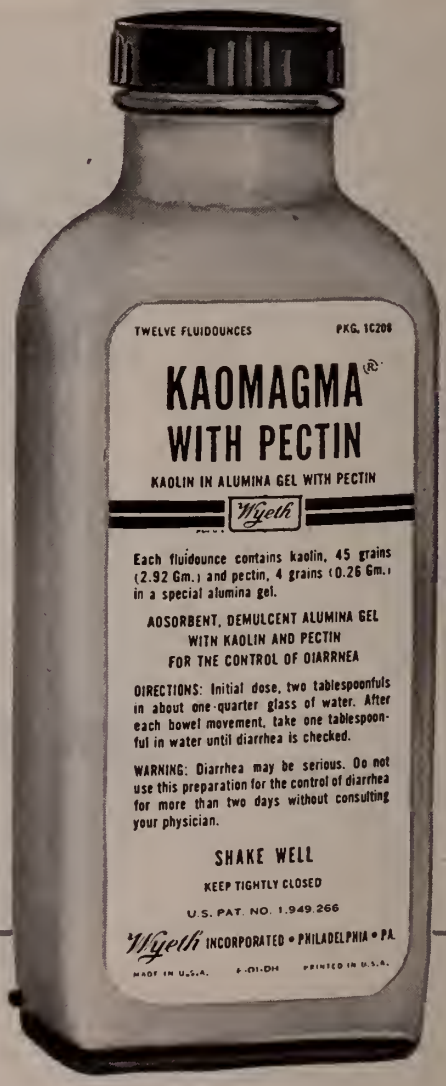
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PRANONE, Anhydrohydroxy-progesterone U.S.P. XIII, Tablets of 5 or 10 mg., boxes of 20, 40, 100 and 250 tablets; also 25 mg., boxes of 20 and 100 tablets.

BIBLIOGRAPHY: 1. Krohn, L., and Harris, J. M.: Am. J. Obst. & Gynec. **41**:95, 1941. 2. Mason, L. W.: Am. J. Obst. & Gynec. **44**:630, 1942. 3. Kotz, J.; Parker, E., and Kaufman, M. S.: J. Clin. Endocrinol. **1**:838, 1941. 4. Mazer, C., and Israel, S. L.: Diagnosis and Treatment of Menstrual Disorders and Sterility, New York, Paul B. Hoeber, Inc., 1941, p. 437.

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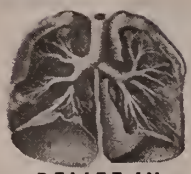
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Aminophylline (Massengill) finds many fields of usefulness in the management of the cardiac patient and the patient afflicted with bronchial asthma.

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A physician's lament over the unreliability of opium prescriptions spurred Sertürner to a 15-year search for the secret locked in the juices of the poppy plant. His addition of ammonia to an opium solution in 1806 caused a formation of gray crystals, from which he succeeded, in 1816, in wresting the real *principium somniferum*—morphine itself.

In its wake have come not only all the barbiturates and milder anodynes, but also many alkaloids isolated by methods similar to Sertürner's: heroin, emetine, quinine, vertabrine, strychnine, etc.—pure, dependable drugs bringing new standards to medicine and dentistry.

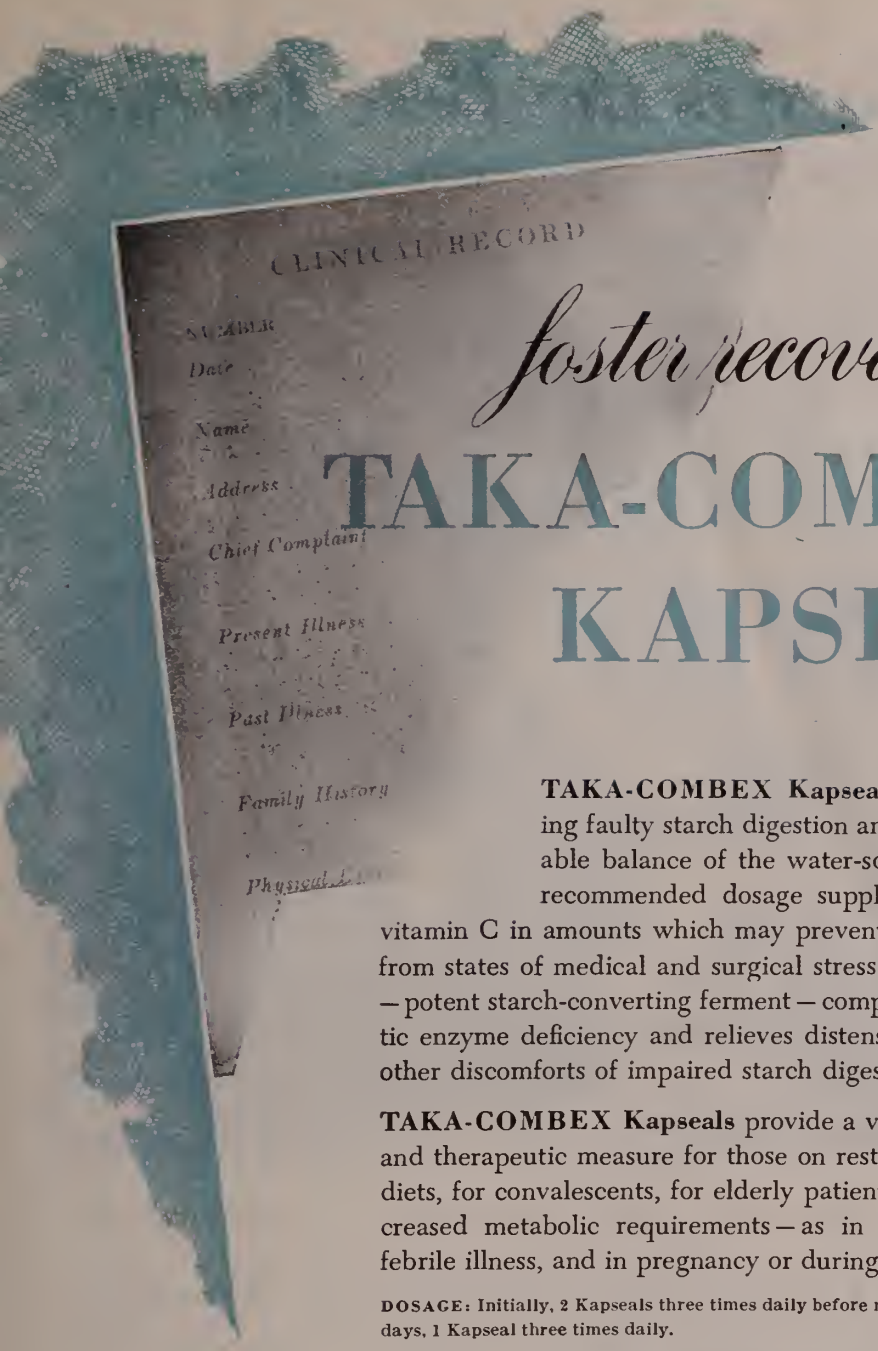
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TAKA-COMBEX Kapseals assist in correcting faulty starch digestion and in restoring favorable balance of the water-soluble vitamins. The recommended dosage supplies B vitamins and vitamin C in amounts which may prevent deficiencies arising from states of medical and surgical stress. TAKA-DIASTASE® — potent starch-converting ferment — compensates for amylolytic enzyme deficiency and relieves distension, eructation, and other discomforts of impaired starch digestion.

TAKA-COMBEX Kapseals provide a valuable prophylactic and therapeutic measure for those on restricted or inadequate diets, for convalescents, for elderly patients, for those with increased metabolic requirements — as in hyperthyroidism, in febrile illness, and in pregnancy or during lactation.

DOSAGE: Initially, 2 Kapseals three times daily before meals; after ten to fourteen days, 1 Kapseal three times daily.



Each TAKA-COMBEX Kapseal Contains:

Taka-Diastase	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	3 mg.
Vitamin B_2 (Riboflavin)	3 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Pantothenic Acid (Sodium salt)	3 mg.
Nicotinamide (Niacinamide)	10 mg.
Vitamin C (Ascorbic Acid)	30 mg.

With other components of the Vitamin B Complex derived from liver.

PACKAGE INFORMATION:
Available in bottles of 100 and 1000.

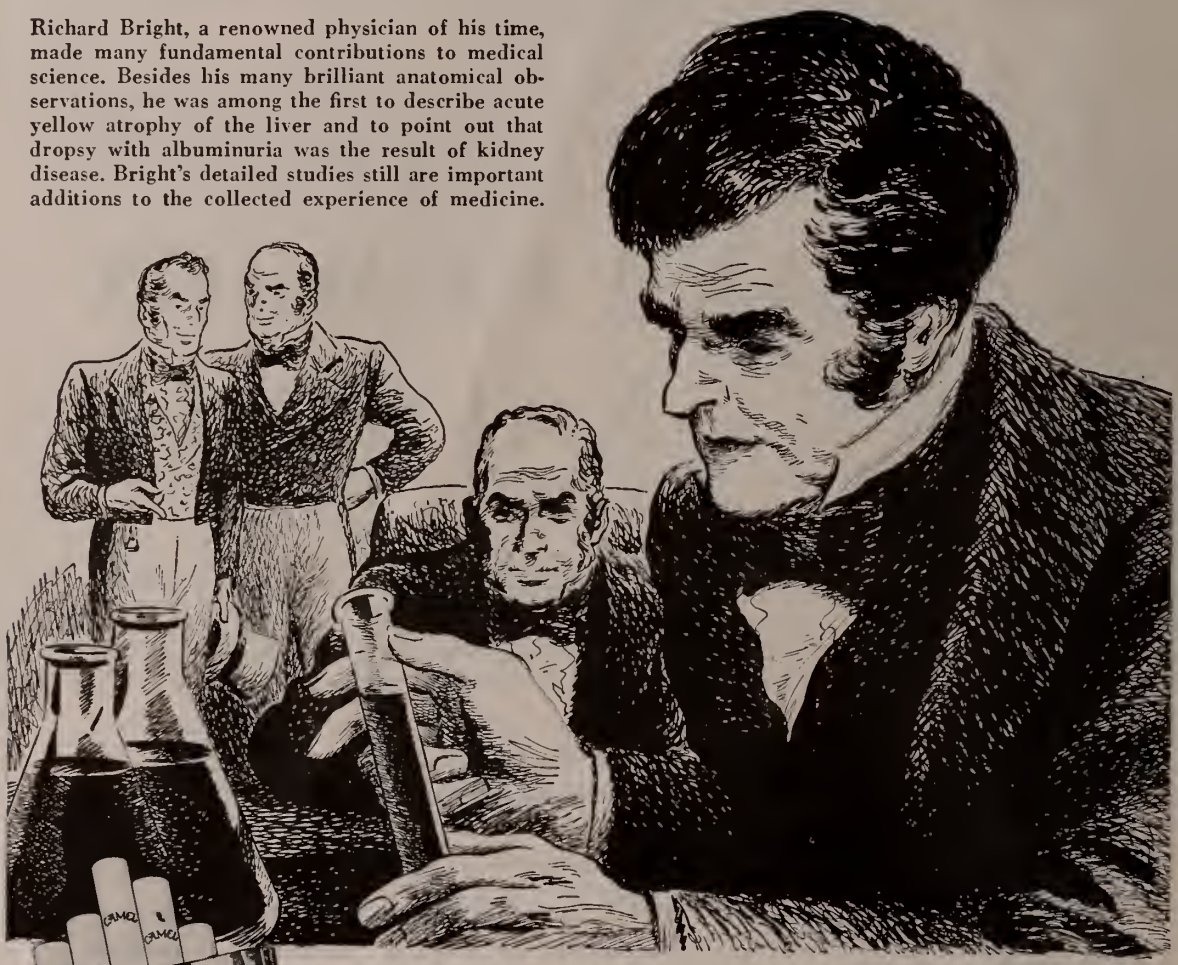
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Experience is the Best Teacher

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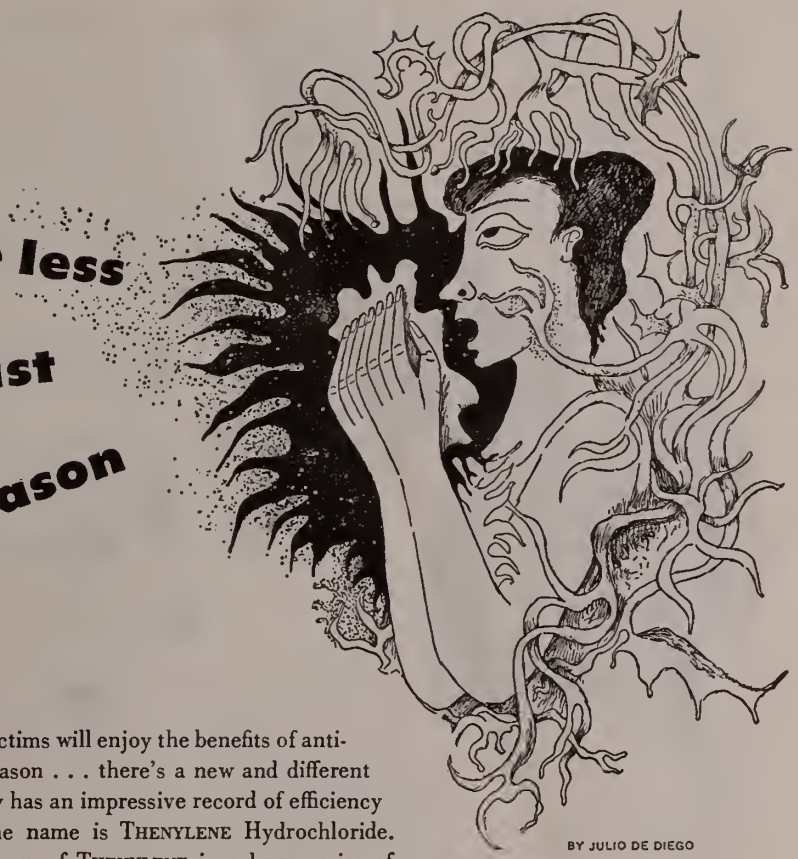
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More Doctors Smoke CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

there'll be less sneeze-mist this season



BY JULIO DE DIEGO

And many more hay fever victims will enjoy the benefits of antihistamine therapy this season . . . there's a new and different compound which already has an impressive record of efficiency *plus* low toxicity. • The name is THENYLENE Hydrochloride. With a dosage of 100 mg. of THENYLENE in a large series of cases, the incidence of undesired reactions was only about 25 percent, and in practically all instances a reduction in dosage to 50 mg. obviated the side-effects.[1] Another study, in which this compound was used, reported that with doses totaling 200 mg. per day, subjective toxic symptoms were usually absent; if they appeared, they frequently did not persist when medication was continued.[2] Still another investigator emphasized that, with THENYLENE, unpleasant side-effects were surprisingly few.[3] • Thus, THENYLENE is safe—safe to try in every case of allergic management. For severe symptoms, prescribe THENYLENE in doses of 100 mg. three or four times daily; as a maintenance dose or for mild symptoms, 25 to 50 mg. It is recommended that antihistamine drugs be used with specific desensitization wherever possible. • Your pharmacy can supply you with THENYLENE Hydrochloride in sugar coated tablets of three sizes, 25 mg., 50 mg. and 0.1 Gm. (100 mg.), in bottles of 100 and 500. For a FREE SAMPLE and detailed literature, drop a card to ABBOTT LABORATORIES, North Chicago, Illinois.

1. Friedlaender, A. S., Friedlaender, S., Amer. J. Med. Sc., in press.
2. Peirce, J. D., Mothersill, M. H. (1947), Treatment of Allergic Symptoms with a New Antihistamine Drug, J. Ind. Sta. Med. Assn., 40:739, Aug. 3. Brunsting, L. A. (1948), Recent Advances in Dermatology and Syphilology, Canadian Med. Assn. J., 58:133, Feb.

Prescribe

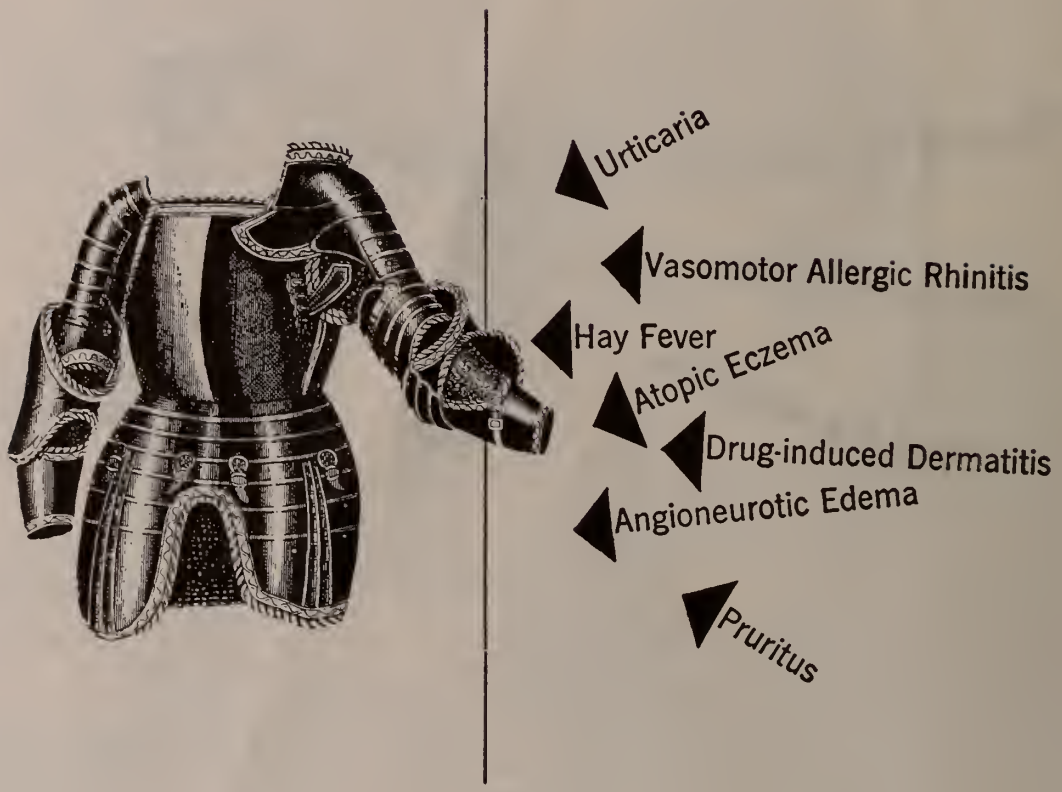
ABBOTT'S NEW ANTIHISTAMINIC

Thenylene®

Hydrochloride

(Methapyrilene Hydrochloride, Abbott)

Armor for the Allergic Patient



Diatrin* *Hydrochloride*

'WARNER'

A superior antihistaminic compound of low toxicity with little or no by-effects.

DIATRIN* hydrochloride 'Warner' provides prompt and effective symptomatic relief in urticaria, angioneurotic edema, hay fever, drug-induced dermatitis, atopic eczema, pruritus, vasomotor allergic rhinitis, the manifestations of which are believed to be due to the release of histamine in the body tissues.

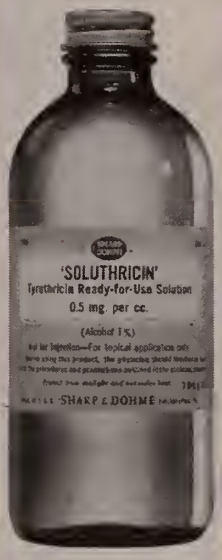
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DIATRIN* hydrochloride 'Warner' is available in sugar-coated oral tablets, 50 mg. each—bottles of 100 and 1,000.

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Tyrothricin solution

ready for instant use!

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Development of special laboratory methods by Sharp & Dohme's Medical Research Division has produced a new, *solubilized* form of tyrothricin ready for immediate use, *sterile* at time of initial application, *clear* in appearance, *stable* at room temperature for more than one year, flocculation and precipitation proof, *ideal* for prescription compounding.

SOLUTHRICIN Solution contains 0.5 mg. of *solubilized* tyrothricin per cc. (0.05%).

It is approximately isotonic with blood serum, and has a surface tension of about 40 dynes per cubic centimeter.

SOLUTHRICIN Solution is for topical use only and is administered by irrigation, wet dressing, drops, spray, or by instillation in body cavities not connected with the blood stream.

SOLUTHRICIN Solution is indicated in treatment of external ulcers, abscesses of the skin and soft tissues, chronic purulent otitis media, mastoiditis, acute sinusitis, osteomyelitis, empyema, and many types of wound and ophthalmic infections. SOLUTHRICIN Solution is supplied in 240-cc. bottles, 0.5 mg. of *solubilized* tyrothricin per cubic centimeter. Sharp & Dohme, Philadelphia 1, Pa.



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"it tastes good!"

Because it tastes so good, children actually like to take Eskadiazine. Important, too, this *fluid* sulfadiazine relieves tired parents and busy nurses of the chore of crushing tablets and coaxing a sick child to swallow an unappealing mixture.

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The outstandingly palatable fluid sulfadiazine

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Pelvicins*

[penicillin vaginal suppositories Schenley]

In a recent controlled study [1] of 1,573 obstetrical patients, the incidence of genital tract infections was reduced from 5.3 per cent to 2.3 per cent when penicillin vaginal suppositories were used. *A decline of 56.6 per cent!*

ADDITIONAL ADVANTAGES: PELVICINS (penicillin vaginal suppositories Schenley) shorten the hospitalization period; reduce nursing care required; are completely painless and nonirritating. These advantages suggest the value of their routine use in obstetrical procedure.

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SUPPLIED: Boxes of 6 and 12 PELVICINS, 100,000 units each.

1. Pierce, R. R.: Am. J. Obst. & Gynec. vol. 55 (Feb.) 1948.

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Nicotinamide	150 mg.
Folic acid	5 mg.
Calcium pantothenate	10 mg.
Vitamin C (ascorbic acid)	150 mg.
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High Potency – Therapeutic Formula – Multiple Vitamin Capsules

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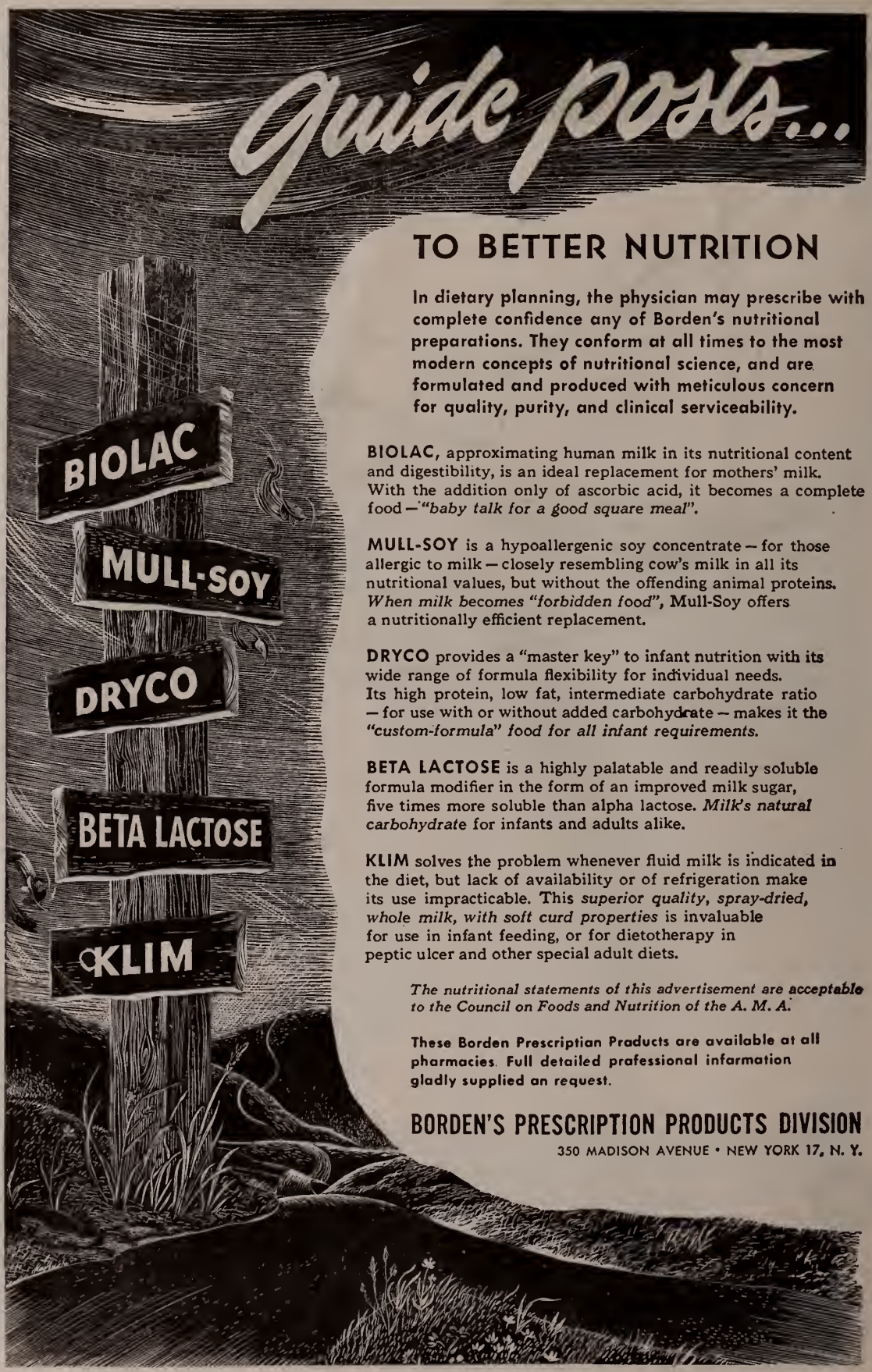
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BIOLAC, approximating human milk in its nutritional content and digestibility, is an ideal replacement for mothers' milk. With the addition only of ascorbic acid, it becomes a complete food—*"baby talk for a good square meal".*

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BETA LACTOSE is a highly palatable and readily soluble formula modifier in the form of an improved milk sugar, five times more soluble than alpha lactose. *Milk's natural carbohydrate* for infants and adults alike.

KLIM solves the problem whenever fluid milk is indicated in the diet, but lack of availability or of refrigeration make its use impracticable. This *superior quality, spray-dried, whole milk, with soft curd properties* is invaluable for use in infant feeding, or for dietotherapy in peptic ulcer and other special adult diets.

The nutritional statements of this advertisement are acceptable to the Council on Foods and Nutrition of the A. M. A.

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Extensive clinical investigation has established that:

★ *Neo-Antergan* produces EFFECTIVE SYMPTOMATIC RELIEF in a high percentage of patients with certain allergic manifestations.

★ This remarkably efficient histamine antagonist possesses a WIDE MARGIN OF SAFETY.

★ Patients who fail to respond satisfactorily to other therapeutic methods may receive effective symptomatic relief from *Neo-Antergan.*

The majority of patients readily tolerate the average therapeutic dose of 50 mg., two to four times daily. In some cases, 25 mg., two to four times daily, will afford appreciable symptomatic relief with minimal side effects. Side reactions, when they occur, have been found to be generally mild and transient. Discontinuance of treatment has been necessary only in *approximately 1½ per cent* of patients.

Your local pharmacy stocks Neo-Antergan in 25-mg. and 50-mg. tablets, supplied in packages of 100 and 1,000.

INDICATIONS: HAY FEVER • PRURITUS • URTICARIA • VASOMOTOR RHINITIS • ATOPIC DERMATITIS ECZEMA • ALLERGIC DRUG REACTIONS • and certain other allergic disorders.





ELAMINE Lyophilized—merits specification for intravenous feeding because it is

... adequate for protein nutrition
... well tolerated
... practically neutral in reaction
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... a Council Accepted Modified Protein Hydrolysate.*

*See Council Report, J.A.M.A. 136:692-693 (March 6) 1948.

Requests for literature and orders for ELAMINE should be addressed directly to the Biochemical Division.

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PROTEIN CHEMISTS — MANUFACTURERS OF AMINO ACIDS



Effective Therapy For the Relief of Menopausal Symptoms

RELATIVELY small doses of Diethylstilbestrol, Lilly, whether given parenterally or orally, can produce the desired result in the control of menopausal symptoms. Excessively large doses of either natural or synthetic estrogenic preparations may cause nausea. A cautious approach in establishing a maintenance dose will prevent untoward reactions. Cyclic administration of Diethylstilbestrol, Lilly, results in an effect which simulates the progression of estrogen levels occurring in normal ovarian cycles.

The dosage forms of Diethylstilbestrol, Lilly, include tablets, ampoules, and vaginal suppositories. They are readily available at your local retail pharmacy.

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Lilly in Switzerland

OF ALL of the admirable qualities of the Swiss people, unselfish, humanitarian service is characteristic. It was a Swiss, Jean Henri Dunant, who founded the Red Cross. The executive committee, known as the International Red Cross Committee, is made up entirely of Swiss citizens. Similar organizations doing private relief work for unfortunates all over the world have their headquarters in Switzerland and are stanchly supported by the Swiss people.

Although Lilly products had been sold in Switzerland for many years, it was not until 1947 that the first Lilly representative was appointed. Those engaged in medical research are now contacted regularly. It is hoped that Eli Lilly and Company will be accorded the privilege of co-operating in the development of discoveries certain to come from the laboratories of Swiss scientists. To make available to all the findings of the world's best medical talent is the goal of Eli Lilly and Company.

LILLY INTERNATIONAL

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 2 August, 1948

THE 1948 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION

The 1948 Annual Meeting of the American Association held in Chicago, June 21-25, was an outstanding meeting from every standpoint. The registration of Fellows was nearly 12,000, with an overall registration of approximately 25,000, thus making it the second largest meeting in the history of the A.M.A

The technical and scientific exhibits were displayed at Navy Pier, which is almost one mile long, so those in attendance had plenty of exercise to see the outstanding exhibits. Likewise many of the general and scientific sessions were held in this same building. For the first time at the annual meeting, television was used, and some fine work was shown by television during the meeting. One outstanding presentation was that of Doctors Stanley Gibson, Willis Potts and Sidney Smith, who took their equipment to the Passavant Hospital, and performed an operation on a "blue baby". There were three places where television receiving sets showing these presentations were located, which gave many physicians an opportunity to see the value of such procedures at a modern medical meeting.

The House of Delegates held its meetings at the Palmer House, and had much business to transact, which required a major portion of the first four days of the meeting. The annual complimentary dinner for the members of the House of Delegates, officers, members of the Board of Trustees, and distinguished guests, was held at the Saddle and Sirloin Club, at the Stockyards Inn. Under the chairmanship of Dr. Percy E. Hopkins, this was an outstanding affair, with the Illinois State Medical Society and the Chicago Medical Society jointly acting as hosts. Dr. Waren W. Furey acted as Toastmaster.

Five of the nine delegates from the Illinois State Medical Society were named as members of reference committees, one of these, Charles H. Phifer being chairman of the important Committee on Executive Sessions. In the large scientific exhibit, Illinois was well represented, there being many exhibits arranged by many members of the Illinois State Medical Society. Illinois exhibitors were likewise well represented in the announcement of awards for outstanding scientific exhibits in the two groups.

Awards in Group 1 (made for exhibits of individual investigation which are judged on the basis of originality and excellence of presentation) found the gold medal going to J. Garrott Allen, Margaret Sanderson, Willadene Egner, Charles McKeen, Richard Elghammer, James Crosbie and Burt Grossman, University of Chicago School of Medicine and Argonne National

Laboratory, Chicago, for the exhibit on Hemorrhagic Disease Caused By Heparinemia — Temporary Control by Toluidine Blue or Protamine Sulfate.

In Group II (awards made for exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of presentation and correlation of facts), the gold medal was awarded to Bertha A. Klien, Chicago, for her exhibit on Diseases of the Fundus Oculi. A Certificate of Merit was awarded to John G. Bellows and Chester J. Farmer, Northwestern University Medical School, Chicago, for the exhibit on Treatment of Ocular Infections — Use of Chemotherapeutic Agents. Another Certificate of Merit went to Miss Georgia Price and Miss Elizabeth F. Carr, Northwestern University Medical Library, Chicago, on "Literature Illustrating the History of Surgery".

The election, as usual, was held on Thursday afternoon, at the closing session of the House of Delegates. The following were elected: Ernest E. Irons, Chicago, President-Elect; Roy W. Fouts, Omaha, Vice President; Francis F. Borzell, Philadelphia, Speaker of the House of Delegates; James R. Rueling, Bayside, New York, Vice-Speaker; George F. Lull, Secretary and General Manager; Josiah J. Moore, Chicago, Treasurer; Members of the Board of Trustees: Edwin S. Hamilton, Kankakee, Resident Trustee; Walter B. Martin, Norfolk, Virginia; Gunnar Gundersen, LaCrosse, Wisconsin.

The 1951 meeting will be held at Atlantic City, this city winning when Chicago and Atlantic City were presented for this honor. Many important actions were taken by the House of Delegates and these will appear in the official transactions to be published in early issues of the Journal of the American Medical Association.

The Interim Meeting will be held at St. Louis, November 30—December 3, 1948.

Everyone attending this fine annual meeting seemed unanimous in the opinion that this was one of the best meetings in the long history of the A. M. A. and likewise many gave the opinion that their local hosts had indeed done a fine job.

Constructive, purposeful activity is far better psychotherapy than a playful waste of leisure time. Ed., Am. Rev. Tbc., Aug., 1947.

DR. ISAAC A. ABT RECEIVED DISTINGUISHED SERVICE AWARD

Dr. Isaac Arthur Abt, distinguished Chicago pediatrician, was awarded the Distinguished Service Medal at the 1948 annual meeting of the American Medical Association, held in Chicago June 21-25. For the past 10 years, at the opening session of the House of Delegates, the Board of Trustees submits a list of three outstanding physicians, giving their qualifications, and the House of Delegates then makes the selection by ballot.

There were three candidates presented, Alfred A. Blalock of Baltimore, Seale Harris of Birmingham, Alabama, and Isaac A. Abt. Doctor Abt received a majority of the ballots cast for the three candidates, and was selected to receive the medal, which was formally presented to him on Tuesday evening, June 22. Doctor Abt, a native of Illinois, was born at Wilmington, December 18, 1947. He was graduated from the Chicago Medical College, which later became Northwestern University Medical School, in 1891. He was probably the first physician in Illinois to be classified as a pediatrician, and for many years was head of the Department of Pediatrics at his Alma Mater.

Doctor Abt is classified as Professor Emeritus of the Department of Diseases of Children at Northwestern, and still maintains his interest in that specialty. He is the author of several books, and has written many scientific papers which have been published widely throughout this country. The many frineds of Doctor Abt in Illinois and throughout the nation were well pleased with his selection for the award, and all were unanimous in the opinion that it was justly deserved.

Although the first Distinguished Service Medical was awarded in 1938, Doctor Abt is the fourth member of the Illinois State Medical Society to receive the medal. Dr. James B. Herrick was the recipient in 1939, Dr. Ludvig Hektoen in 1942, and Dr. Anton J. Carlosn received it in 1946.

The many friends of Doctor Abt are desirous of offering their sincere congratulations for the well deserved honor bestowed upon him, and also their best wishes to him for a continuance of the outstanding work which he has been doing over a long period of years.

THE PHYSICIAN AND VETERAN GROUPS

Col. Paul G. Armstrong

Frequently, there has been criticism voiced by members of the medical profession against some of the policies supported by our great veterans organizations. Principal criticism has been directed against the American Legion which, since World War I, has been the most powerful in numbers and in influence.

It was the Legion some 28 years ago that conceived and introduced legislation in the Congress which combined some 5 or 6 bureaus, each one handling some phase of veterans affairs, into one agency now known as the Veterans Administration, under whose jurisdiction the largest hospital system in the world is operated. The Legion has initiated and caused the passage of legislation to improve, expand and strengthen this great organization. Most of the time, at least on the post levels where resolutions originate, there have been few, if any, medical men available to advise on unwise projects. After post action on a resolution, it goes on up through County and State levels to the National Convention where, if adopted, it becomes a part of the Legion's mandated program. If legislation is in order, proper bills are prepared by the National Legislative Director, Colonel John Thomas Taylor, and presented to Congress for passage.

Sometimes these bills are contrary to the policy of the medical fraternity, yet when we withhold our membership and participation in the policy making of the Legion or other veteran groups, we really don't have much right to criticize. The Legion welcomes and needs your assistance and, conversely, you need them.

The American Legion, by National Convention, has directed Colonel Taylor, their legislative representative, to *oppose* the Wagner, Murray, Dingle bill on socialized medicine. They have, whenever possible, in accordance with their policy, cooperated with our organization.

The American Legion has a national medical advisory committee made up of some of our most distinguished and able doctors. Dr. Leonard Rowntree is Chairman, among the members are such men as Drs. Charles Mayo; William D. Stroud, Heart Specialist; William Overholser of St. Elizabeth's Hospital, Washington, D. C.; and other noted specialists. They meet at the Legion's National Rehabilitation office in Washington every month, more often if needed, advises with the Legion staff which includes Dr. Hyman D. Shapiro and, at the appropriate time and on approprite subjects, with the medical Director of the Veterans Administration.

However, this committee, even though it includes such distinguished physicians, cannot do everything that should be done for the veteran and for the medical profession; they need help at the post and county advisors, *not* to give free medical service, that is not expected, but rather to advise on the many complex medical problems that arise in connection with medical care and rehabilitation of our almost 19 million veterans of all wars; to cooperate with an organization that can give powerful help in opposition to the socialization of medicine: that can and does do a great deal in its child welfare programs to reduce juvenile delinquency and to make the community a better place in which to live.

In its many programs the Legion needs the help of your knowledge and ability and you on the other hand need the Legion.

Mike Clancy had been working on New York harbor tugboats for 50 years when he fell overboard and was drowned. This brought about a very fine wake, at which the highest praise was given the deceased and all the traditional ceremonies were observed.

During the proceedings, a friend of the widow asked her: "Did Mike leave you well fixed?"

"Shure, an' he did me that. 'Tis 50 thousand he's after leaving me."

The friend rolled her eyes heavenward. "Tch, tch, tch," she said, "Think of that. And him that couldn't read nor write."

"Yes," agreed the widow, shaking her head seriously, "nor swim."

STATE DEPARTMENT OF PUBLIC HEALTH



Hospital Survey and Construction Plan in Illinois Gets Under Way

In the presence of several hundred enthusiastic Clay County citizens, ground was broken on June 11 for a fifty-bed hospital in Flora, Illinois, which will be one of a series of hospitals so located that a hospital will be within a thirty-mile reach of every family in Illinois.

When Dr. M. W. Bowman, representing the Clay County Medical Society, addressed the audience from the speakers' platform erected on the site of the hospital, he voiced the urgent need of all medical practitioners for adequate hospital facilities, particularly in the southern part of the State.

Lawrenceville has 7th priority and will soon start a 50-bed general hospital.

Carthage, with 8th priority, now sends many patients out of the state, 14 miles to Keokuk. It is 26 miles to Macomb, 40 miles to Quincy, and 73 miles to Canton. When this 50-bed hospital is completed, this community will be self-sufficient.

Red Bud with 12th priority will complete a structure which had been started in 1945 before the statewide plan went into effect. Realizing that their funds, under rising costs, would not be sufficient to build their entire hospital, they stopped with the central portion, and later applied for aid under the hospital plan to add the two wings, which will provide total of 63 beds.

Aledo has 13th priority and is the last hospital which can be started this fiscal year using Federal and State grant-in-aid funds. Fifty beds will be provided. Like the other seven places mentioned, Aledo is in a county without any hospital facilities.

By the term "no hospital facilities," is meant *acceptable* hospital beds. The lack of acceptable beds in a given area is one of the factors which determines priority. To be considered "acceptable," the beds must be in a fire-resistant building, one that is less than 50 years old, and one that was built expressly for a hospital. According to this standard, one-half of the counties in Ilinois are without hospital facilities. Most of these same counties have the highest death and morbidity rates from controllable causes. These



Speaking at the Flora Hospital ceremony, Dr. N. W. Bowman, representing the Clay County Medical Society, told the audience that the medical profession in many parts of Illinois is seriously handicapped by the lack of hospital facilities. It is hoped that hospitals located in rural sections of the state will attract young doctors and nurses to the smaller towns and cities, where there is at present a serious lack of doctors and nurses. Dr. E. D. Foss, a member of the Reception Committee, and Dr. L. L. Hutchens, County Hospital Chairman of the medical association, also took part in the program.

counties are often in blocks, and are mainly in the southern part of the state in areas of low economic status.

One other building project should be mentioned at this time, namely, the tuberculosis sanatorium blue-printed for Mount Vernon. In 1945 a site was purchased with funds from a state appropriation for tuberculosis hospitals. The next legislature made another appropriation for three state-owned and managed tuberculosis hospitals of which Mount Vernon was one. It will have 102 beds, and is in addition to the general hospital which is also being built in Mount Vernon.

The eight structures listed have priority numbers 1, 3, 5, 6, 7, 8, 12 and 13 under the plan. What about the places with priority numbers 2, 4, 9, 10, and 11? They are Metropolis, Robinson, and Cairo where planning is underway, but building is not immediate; there is early activity in Carlinville but there is no manifest activity in Chester. Thus of the 13 places having priorities for this year's program, all but one community is taking advantage of the opportunity to secure hospitals.

Representing the Illinois Department of Public Health, Dr. Roland R. Cross led in the ground-breaking exercises. Representing the U. S. Public Health Service, Dr. Joseph L. Mountin, Assistant Surgeon General, delivered one of the major addresses. The Illinois State Dental Society was represented by Dr. Paul W. Clopper. Members of the Board of Supervisors, the local hospital committee, and visitors from many parts of the State, sat on the platform.

The ground-breaking ceremony in Flora was the culmination of a series of events started three years ago by the citizens of Clay County. After the enactment of the Federal and State Hospital Construction Acts in 1946 and 1947, respectively, the local interests joined forces with the Illinois State Department of Public Health, and the Federal Government in order to attain the hospital in the Clay County area which was one of the localities in greatest need of such facilities.

Within the next two months actual construction under the Federal and State Hospital Programs is expected to have started on hospital buildings in five other towns in Illinois. These are Anna, Mount Vernon, Fairfield, Lawrenceville, and Aledo. Construction was resumed on the St. Clement's Hospital in Red Bud the latter part of April. The Hospital Association in Carthage is now conducting a fund-raising campaign and the hospital for this area is expected to be under construction sometime this fall.

First on the priority list is a 58-bed general hospital in Anna which will rise from the center of a so-called "hospital area" of about 23,220 people, located 37 miles from a hospital in Cairo, 21 miles from a small hospital in Carbondale, 43 miles from a hospital in Metropolis and 31 miles from one in Herrin. Anna was given No. 1 priority in the Illinois construction plan because of its distance from existing hospitals; its total lack of acceptable hospital beds; its high percentage of ruralness; its low per capita income; its low assessed property valuation; and

its large proportion of population receiving public aid. These three economic indices plus the lack of acceptable hospital beds and the percentage of ruralness, are the factors which determine the priority of each of the 74 hospital areas into which the state has been divided in the construction plan.

Flora, in an area of 16,787 population, 23 miles from the hospital at Olney, 33 and 25 miles from hospitals in Effingham and Salem, respectively, stands third on the priority list.

Mount Vernon is in 5th place as to priority, and will start a new 131-bed general hospital which will serve an area with 40,341 population.

Distances of 32 and 42 miles from hospitals helped to put *Fairfield* in 6th place on the priority list, and Fairfield will soon start a 100-bed hospital.

To some, the hospital construction plan may seem to be a cold, scientifically planned program on the part of the Federal and State governments; based on economic, geographical, sociological factors; worked out statistically, and administered impartially and impersonally. But to the people of the many areas of Illinois lacking hospital facilities, the Plan and the available financial assistance offer sound encouragement to their spontaneous efforts for desperately needed service—beds for the sick, beds for the increasing number of people who carry hospital insurance; obstetric service; care of the aged and chronics; headquarters for public health work in preventing sickness. The way the ball starts rolling in the different communities is interesting.

In three of the eight communities where construction will soon be started, the boards of supervisors had, after careful consideration, decided to build county hospitals before the State Plan was announced. They immediately applied for participation when they heard of it. In two other towns the idea started with small citizen groups — five or six persons in Fairfield, about twelve in Carthage — the doctor, the banker, a lawyer, the veterinarian, the undertaker and some civic-minded women.

The town of Anna had received a bequest of about $175,000 for a hospital. Then came the offer of State and Federal aid which, added to the bequest, was enough to start work. Anna also had the distinction of being in the second lowest bracket of buying power, the lowest bracket of assessed valuation of property, 19th county in the state in amount of public aid, one of the 20 counties with no acceptable hospital beds, and in the highest rural brackets. All this added up to a top priority—and besides there was the bequest.

Non-profit hospitals in other communities were in great need of reconstruction and additions. As soon as it became public, the Hospital Plan was eagerly investigated by distraught boards of directors and hospital owners.

Th local planning of hospitals has been done in conjunction with the county medical society as a body. The projects have therefore reflected the thinking and wishes of the medical profession.

Applications for hospital funds are, under Public Law 725, submitted to the Illinois Department of Public Health which is the agency of the state government designated by the State Legislature to administer the law in Illinois. The project must be in an area of need and the applicants must conform to the requirements of non-discrimination, services for persons unable to pay, minimum rates of pay for construction, competitive bidding, lump sum contracts and other matters.

The Federal law requires that a hospital must either be "public," meaning that it is built by a political subdivision (city, county, etc.), or that it must be a voluntary non-profit corporation in order to be eligible for financial assistance.

The State Plan to which all applicants must conform was developed by the Department of Public Health after a study had been made of hospital needs in Illinois during 1945. At this time the so-called Hill-Burton hospital bill was still being considered in Congress. The data from this study formed the basis for the statewide plan which became known as the "Illinois Hospital Survey and Plan" and which was submitted to the U. S. Public Health Service late in July 1947. On August 8, 1947, it was approved by the Surgeon General as meeting all the requirements of the Federal Hospital Survey and Construction Act (Hill-Burton Bill) which had, in the meantime, been passed by Congress.

This Federal law requires that rural communities with the greatest need and the least financial resources be given first consideration in the distribution of grants-in-aid for hospital

construction. These criteria were used in establishing the Illinois area priorities for equitable allocation of funds. In compliance with the federal law, Governor Dwight H. Green has appointed an Advisory Hospital Council to advise and assist the Department of Health in this program.

This same Federal Act authorized an appropriation of 75 million dollars each year for five years as contractual obligations of the Federal government for grants for the construction of hospitals, in the proportion of one-third federal funds to two-thirds state and local funds. Illinois will recieve $2,770,725 per year for five years on the basis of present authorization and formula.

The Illinois State Legislature made appropriations to meet up to one-third of the cost of construction of any eligible hospital. This leaves at least one-third of the costs to be raised locally. Local quotas are being raised in various ways—through the establishment of Hospital Authorities with permission to issue bonds; through county bond issues; through local subscriptions; through bequests and other means.

The Illinois Legislature cooperated fully in the general plan. Besides appropriating funds to pay up to one-third of construction costs, the legislature enacted a number of laws which were necessary or advisable for the implementation of the Plan.

First, sections of the Civil Administrative Code had to be amended in such a way as to designate the Department of Public Health as the agency to administer the hospital program. Amendments were also made to create a hospital advisory council.

Second, a licensing law was enacted which provides for the establishment of minimum standards relating to the operation and maintenance of hospitals receiving financial assistance. This was necessary in order to qualify for federal grants.

Third, an act authorizing the establishment of Hospital Authorities was passed. This is intended to provide a method by which funds can be raised through a bond issue for the construction and through a tax levy for operation of hospitals under local management. It provides for the creation, by popular vote, of a board known as a Hospital Authority which can sell bonds and tax a specified area, independent of county lines, for the construction and operation of a hospital. Projects financed under the provisions of this law would be eligible to participate in State and Federal funds if the projects conform to the State plan.

As to the future, the priority numbers which may come up for the next fiscal year are those of No. 2 Metropolis, No. 4 Robinson, No. 9 Cairo, No. 10 Carlinville, No. 14 Mt. Carmel, No. 15 Carmi, No. 17 Olney — depending on how far the available funds will stretch. In these localities there is already a considerable amount of interest and activity and some committees have progressed rather far with preliminary plans for construction.

Under the law Congress is authorized to appropriate funds for hospital construction up to June 30, 1951, but the actual appropriation must be made each year. Likewise the Illinois legislature must continue to make an appropriation for each biennium if the State is to continue its participation in the enterprise. At this time eight states have appropriated State monies to aid in realizing the general hospital facilities planned in accordance with the Hospital Survey and Construction Act.

At an average rate of 500 beds a year, it would take at least 12 years for Illinois to provide the needed hospital facilities for the hospital areas set up in the plan. Any break in the continuity of the plan, for financial or political reasons, would be regrettable. If carried to completion the plan will produce a distribution of hospital facilities that should tend to bring about more equitable distribution of doctors and nurses throughout the state. The shortage of doctors in rural Illinois, particularly in southern Illinois, is as acute as the shortage of hospitals. Doctors naturally gravitate to the medical centers where they find the necessary facilities for the practice of medicine. This has resulted in a concentration of doctors in some localities and a scarcity of doctors in others. It is believed that having good hospitals close at hand will attract young medical graduates back to their home communities or to the more rural areas. The same reasoning applies to the distribution of nurses and other technical personnel.

The master plan for hospitals in Illinois was evolved jointly by individuals and organizations with expert knowledge and long experience in

the subject. The Plan was created in an atmosphere completely free from self interest and political pressures. It is shaped to provide the most service to the greatest number of areas for the least money. In all probability, an equal amount of money spent for hospitals but spent without a plan would result in the perpetuation of the long existing maldistribution of facilities and the comparable distribution of health service personnel.

ONE OF EACH FIVE APPLICANTS ACCEPTED AT U. OF I.

The University of Illinois college of medicine will be unable to accommodate more than one out of every five applicants for admission to its 1948-49 freshman class because of limited classroom and hospital clinical facilities.

Registrar George R. Moon announced recently that applications for admission to the freshman class in medicine totaled 845. The number maintains the post-war record level of applications which is the highest in the 61-year old history of the college of medicine.

The college has accepted 166 students, including five women, for enrollment in the fall term starting September 27. Approximately half of those accepted are residents of Cook County, with the remaining half from downstate communities.

The number of qualified applicants — those with averages of 84 percent or better — totaled 636. Because of the large number of applicants, consideration was primarily limited to those whose averages were 88 percent or above.

Despite the great demand for admission, Dean John B. Youmans said that it would be impossible to increase the enrollment in medicine until additional facilities are available. The college now has only 1.6 hospital beds available per student for teaching purposes. Four hospital beds per student are considered necessary for the junior and senior years of medical education.

The University has formulated plans for the erection of a $6,500,000 addition to its 428-bed research and educational hospitals and a $5,000,000 classroom unit for the colleges of medicine, dentistry, and pharmacy. The proposals are now under consideration by the University's building committee, and, if approved, will be included in the UI building request to the state legislature for the 1949-51 biennium.

The University's 1948-49 freshman class in medicine will represent the largest single group accepted by any school in the nation. The college of medicine also has the largest faculty with more than 900 full and part-time teachers.

Factors in the selection of students for the freshman class, in addition to scholarship, were the results of a professional aptitude test supervised by the Association of American Medical Colleges, recommendations from science teachers and pre-medical counselors, ratings on interviews with at least two members of the college of medicine faculty, and a physical examination.

Preferential consideration was given to veterans. Three years of college work is required for admission to medical school. Because of the large number of applicants, however, non-veterans, particularly those who were only 19 or 20 years of age, were required to have four years of college.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Emmet B. Bay, Edwin F. Baker, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Ford K. Hick, Edwin F. Hirsch, May McDonald Milligan, Marie Wessels, Walter M. Whitaker, Holland Williamson.



Vacations

Prescription for a busy doctor: one vacation twice yearly — take as desired for relief of jitters, restlessness, difficulty in thinking and assorted headaches.

We order patients to get away and see in them numerous benefits of similar prescription. Current thinking approves vacations. They are acceptable to the U. S. Government, to the Civil Service, to the United Mine Workers and to most corporations. In principle every one admits a vacation is desirable. Creative work in design, music, science, writing, medicine, law, teaching, and administration demands longer and more effective vacations than do the tasks which require less imaginative effort. Farmers, especially those who love the soil have told me, "I don't need a vacation" and then explain the pleasures of their work and daily living a gratification in achievement which is truly satisfying. Few physicians can so well balance the day's energy output with rest and recreation so that each day ends profitably in terms of energy. Most physicians get too little exercise, too long hours, irregularity of living habits and have too little recreation in terms of hobbies or fun activities at home. As a result of intense application a variety of fatigue or staleness appears even if the doctor is still young and even if he is in good health.

The individual should be privileged to take his vacations as he needs them. Perhaps a long weekend timed properly can put a man in good enough shape to carry on for a time. In older men longer vacations are more to be desired. Summer holidays are the choice of younger men particularly with children, whereas, older men often prefer a winter vacation in the South. Such decisions are highly individual often dictated by reasons of health in the doctor or his immediate family. The common aim is *escape,* without pharmacologic assistance) from fatigue, boredom, responsibility and routine. A vacation is not intended to correct an involutional psychosis or to cure any undiagnosed ailments. The greatest benefits of a vacation go to those in good health. It is hygienic, not curative.

Doctors have many ways of paying office expenses while on vacation. Partnerships and

clinics plan for vacations for their professional men and usually plan generously, utilizing the "slack season." Individual physicians may be able to shut the office entirely and give the office help some time off also. A friend may keep office hours if the practice requires it. The hospital or exchange can direct your calls to a man of your choosing. In most communities some capable physician can be had as your relief man. How you repay him is for you to decide. No honest method would be criticized. Local customs differ but are still dependent on personal agreements and on good-humored friendliness. Smith will gladly look out for Dr. Jones during his absence because that will get a vacation for Smith some day.

Note on Income Tax — At present a significant part of our annual income goes to the Government. The lower our income the lower the tax. The higher the income the greater the tax. Therefore on a lifetime income of $400,000, the longer the period over which it spreads the lower the tax. The nearest approach to a loophole in the income tax system is organization as an educational institution; but a strong man can do something for himself by maintaining some income through the sixties and often enough the seventies. Perhaps the prescription of one vacation twice yearly as desired may help you reduce your life time taxes by spreading them over four or more decades.

For advice as to what to do on vacation we suggest consultation with — your wife — she probably needs it worse than you do.—F. K. H.

SEAT NEXT TO DRIVER CALLED MOST DANGEROUS

Automobile passengers occupying the front seat next to the driver are in the most dangerous position in the car, according to a Detroit plastic surgeon writing in the May 22 issue of the Journal of the American Medical Association.

In his report, Claire L. Straith, M. D., chief of the Plastic Surgery Division, Harper Hospital, Detroit, says:

"Drivers occupy the safest seat in the car; protected by the steering wheel, they escape injury in many severe accidents. 'Guest passengers' in the front seat beside the driver are, on the contrary, in the most dangerous seat in the car because of their unprotected position in case of sudden stops."

According to the article, occupants of the "death seat" beside the driver are injured at the rate of about three to one, as compared to the driver. In study of 50 consecutive patients with facial injuries from automobile accidents, Dr. Straith discovered that about 70 per cent were young women and girls who had been riding in the front seat next to the driver.

Substantiating his "death seat" theory, the Detroit surgeon cites figures secured from the Detroit police department, showing that in 219 accidents involving multiple occupants, 260 passengers but no drivers were injured.

According to the article, the Detroit study showed that more than half of those front seat passengers involved in auto accidents sustained injuries of the head, including facial cuts and damage to the teeth, chin, nose, cheeks, ears, forehead and skull.

Among the remedies suggested by the writer to reduce the "death seat" danger are removal of all knobs, cranks, drop down ash trays and sharp ledges from the dash board, and the use of rubber padding on the dash in front of the guest passenger.

CORRESPONDENCE



ORIENTATION COURSE IN ALLERGY AT N.U

Northwestern University Medical School will offer a 5 day orientation course in allergy under the sponsorship of the American Academy of Allergy, October 25-29 inclusive. The course will comprise a complete and practical coverage of the subject and will utilize teachers not only from Northwestern University, but also from other local and out-of-town medical schools. For particulars direct communications to Department of Allergy, Northwestern University Medical School, Chicago.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-sixth annual scientific and clinical session Sept. 7, 8, 9, 10 and 11 inclusive, at the Hotel Statler, Washington, D. C. Scientific and clinical sessions will be given the days of Sept. 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held Sept. 7, 8, 9 and 10. These courses will be offered in two groups. One set of ten lectures will be based primarily on physics and physiology and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapists. The physical therapists must be registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

SAUNDERS APPOINTED ASSOCIATE DIRECTOR

Dr. H. Prather Saunders has been appointed an Associate Director by the Board of Regents of the American College of Surgeons, effective June 1, 1948. The other associate directors are Dr. Malcolm T. MacEachern, Chairman of the Administrative Board, and Dr. Bowman C. Crowell, Vice Chairman.

Dr. Saunders joined the staff of the College on March 16, 1946, as Assistant Director. This was immediately upon his return from active duty in the Medical Corps of the United States Navy, from which he was released with the rank of Commander. He served in the Navy for four years, during which time he spent 21 months in the Pacific as Senior Medical Officer of a destroyer tender which was equipped with a sick

bay equivalent to a 60-bed hospital, furnishing surgical and medical service to its own crew and also the personnel of smaller ships such as destroyers and destroyer escorts.

Dr. Saunders was born in Kentucky, received an A. B. degree and a two-year Certificate in Medicine from the University of Missouri in 1917, and graduated with an M.D. degree from the University of Illinois in 1919, serving as instructor in physiology at the latter school simultaneously with an internship and residency at Lakeview Hospital from 1919 to 1921. He is a Fellow of the American College of Surgeons and a member of Phi Beta Phi and Alpha Omega Alpha.

OBSTETRICIANS WILL MEET IN DENVER

The Sixteenth Annual Meeting of the Central Association of Obstetricians and Gynecologists is to take place in Denver, Colorado, on September 23, 24 and 25, 1948.

The Shirley-Savoy Hotel is the Convention Headquarters and the Executive Committee will meet there on Wednesday, September 22 just preceding the Annual Meeting.

MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING AT SPRINGFIELD

The 13th Annual Meeting, Mississippi Valley Medical Society, will be held at the Abraham-Lincoln Hotel, Springfield, Ill., Sept. 29, 30, Oct. 1, under the Presidency of Dr. Willard O. Thompson, Prof. of Medicine, University of Illinois College of Medicine. Over 25 clinical teachers will conduct this post-graduate assembly, whose program is planned to appeal to general practitioners. No registration fee will be charged and every ethical physician is cordially invited and urged to attend. The entire program and all exhibits will be held in the Abraham-Lincoln Hotel. A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Illinois.

A.C.S. CLINICAL CONGRESS TO BE IN LOS ANGELES

The thirty-fourth Clinical Congress of the American College of Surgeons will be held in Los Angeles, with headquarters at the Biltmore Hotel, from October 18 to 22, 1948. The program of scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurological surgery, will be supplemented by operative clinics in hospitals in Los Angeles and vicinity by showings of operations by television and motion pictures, and by a four-day hospital standardization conference for hospital personnel, acording to Dr. Irvin Abell of Louisville, Chairman of the Board of Regents of the College. There will also be extensive technical and scientific exhibits.

Among new officers who will be inaugurated at the opening evening session is Dr. Dallas B. Phemister, Chicago, as President.

At the Convocation which will be held on the final evening of the Clinical Congress, some 600 initiates will be received into fellowship. The American College of Surgeons, which was organized in 1913 to elevate the standards of surgery, now has a total fellowship of more than 15,000 surgeons in North, Central, and South America, and in a few other countries.

HERRICK HOUSE FOR CONVALESCENT CHILDREN

Children recovering from rheumatic fever, but not yet well enough to attend public school, and who are between the ages of 8 and 14 years, may be referred by their physicians for convalescent care at Herrick House.

Herrick House, at Bartlett, Illinois (35 miles from Chicago, near Elgin), is a year-round convalescent center, including elementary school in the building which is part of the Cook County School System. Fees are based on parents' ability to pay, and some children receive free care. For further information call Sunset Camp Service League, Wabash 5379, or write 343 South Dearborn, Chicago 4. Philip Rosenblum, M.D., Medical Director.

ORIGINAL ARTICLES



Problems of Medical Care in the Atomic Age

Harold C. Lueth, M.D.
Dean, University of Nebraska College of Medicine
Omaha

The dropping of the atom bomb on Hiroshima shook the world into a new epoch. Each new weapon of war affects the course of war. Inventions have their effects on the social life of communities. Gunpowder broke down the defensive system of body armour; castles, and fortresses and within a relatively short time after its introduction, the feudal system, so inextricably interwoven with the older types of warfare, disappeared. The steam engine, the steel vessel, the automobile, the airplane and the radio, in turn, profoundly affected warfare and the social order. When the first atom bomb fell, it marked the beginning of a new era. At first there were exaggerated reports of the damage of the atom bomb, but now since calm reason and scientific measurement have supplanted emotional utterances we have definite knowledge of the probabilities and the realities of an atomic age. The task of giving medical care to populations subjected to atom bombing requires careful planning, the mobilization of physicians, nurses and hospital personnel, and providing medical and hospital supplies on a much larger scale than has been usually considered adequate to meet an emergency.

Picture a moderately large city with its normal business activity. Then think of the havoc and wholesale confusion that would follow if an atom bomb were dropped on the city. All persons living within a radius of about two thirds of a mile from the center of the bomb explosion would be killed instantly. In an outer zone, approximately five miles in diameter, many people would be killed by blast, burns, or flying missiles. Medical, nursing and hospital services would be suddenly overwhelmed by the staggering number of casualties. Communication and transportation

Given before the Veterans Service and Secretaries Conference, Illinois Medical Society, May 10, 1948, Chicago, Illinois.

facilities would stop immediately after the explosion and the roads leading from the area would be crowded with refugees soon after the blast. Many small fires would gain headway and burn areas not initially burned by the bomb. A wide zone of destruction would develop as the fire fighting services would be helpless. Lack of personnel, difficulties of moving equipment, and low water pressure would allow the fires to burn virtually unchecked. This is not a flight of the imagination or a passage from a Jules Verne novel, but a factual recitation of the conditions that took place in Hiroshima and in Nagasaki.

As far as is known there were five atom bombs detonated in the world. A test bomb at Alamogorda, New Mexico, on July 16, 1945 was the first one.[1] It was followed by the aerial bombs at Hiroshima on August 6 and at Nagasaki on August 9, 1945. Two test bombs were used in the Marshall Islands as part of the exercises called "Operations Cross Roads": (1) An aerial bomb was exploded on July 1, 1946 over the lagoon at Bikini, (Test Able) and (2) for the first time in history an underwater atom bomb explosion took place in the lagoon on July 25, 1946 (Test Baker).[2]

The physical effects of the atom bomb are of great interest to the medical profession as they indicate the types of casualities likely to be encountered. Such tremendous forces are released as the result of nuclear fission when an atom bomb is exploded that it is difficult to realize their magnitude. A little more than a year ago a former Assistant Secretary of War wrote, "We talk today of the bomb in terms of the equivalent of twenty thousand tons of TNT."[3] After the detonation of an atom bomb there is a tremendous liberation of energy that is manifest in pressure, heat, and radioactivity. The expanding gases heated to high temperatures develop intense pressures that spread from the center of the explosion and are called pressure waves or blast.

Blast or the physical phenomenon accompanying explosions has been studied for more than 30 years as it followed artillery fire or aerial bombing with high explosives (H.E.). The effects of blast on personnel have been adequately described in the medical literature. Men in secure dug outs or reinforced concrete emplacements were found dead after severe high explosive bombardment, though few or no external signs of trauma were found on their bodies. The high pressure wave emmanating from the center of the explosion and spreading equally in all directions is known as the positive phase of blast. It reaches its maximum intensity within 0.0001 to 0.002 second and has an initial speed of about two or three times that of velocity of sound.[7] Compressed gas moves quite rapidly from the center immediately after an explosion, for example after a 60 pound charge of H.E. the wave is moving 1500 feet per second 30 feet from the charge. Blast acts as an additional wind pressure to all objects in its path. Intensity of blast pressure varies inversely as the square of the distance from the site of explosion. Immediately about the center of the explosion all objects will be subjected to many times atmospheric pressure, while some distance away there will be considerably less pressure. Zuckerman[4] reported hydrostatic pressures of 200 pounds per square inch above atmospheric at a distance of 15 feet from a 125 pound charge of H.E., whereas 50 feet from the explosion the pressure was not more than 10 pounds per square inch. Severity of explosion determines the intensity of blast and the distance over which it is effective.

Many observers have described the effects of blast on persons in the central zone of an explosion. All bodies show signs of violence, avulsion of limbs, or complete disintegration.[8] It has been postulated by Dr. Stafford Warren[9] that many of the people of Hiroshima and Nagasaki near the epicenters of the atom bombs were killed by blast.

Blast includes two components: one of which is the positive pressure wave followed by a more slowly moving wave of negative pressure or suction. Ordinarily, the positive pressure phase which is a building up of high pressure moves so fast that it leaves a partial vacuum behind it, called suction wave. In the case of high explosives frequently the double effect of positive and negative pressure has produced striking effects in the body especially in the lungs. It has been shown by Zuckerman,[4] Dean, Thomas and Allison,[5] King and Curtis[6] and others[7,8,11,12,13] that the thoracic cage is forcefully compressed about the lungs severely damaging the tissues during blast. Then, when the longer wave of negative pressure follows, the thoracic cage and lungs are simply sucked back, producing additional minute hemorrhages. The positive

pressure phase of the atom bomb blast is so intense, so destructive to both physical structures and personnel that the negative phase adds little damage. Surrounding the epicenter, or in the second zone, undoubtedly many people were killed by traumatic hemorrhages of the lungs and from other effects of blast. Difficulties of rescue workers in reaching the Japanese bombed cities in sufficient numbers, and in time to give aid to the wounded have made it hard to estimate the number killed by blast. Experiments performed as part of TEST ABLE showed that about ten per cent of the 3500 animals (including goats, pigs, guinea pigs, mice and albino rats) held captive on the target ships were killed almost instantly from the blast or heat, or both. In contrast, animals sheltered in the sick bays of the vessels used in TEST BAKER were not effected by blast or heat.[2] Motion picture films of the tests at Bikini showed blast waves preceded the secondary large waves of water.

Heat was the second most destructive action of the atom bomb. In all explosions the sudden release of energy is in part converted into heat and produces enormous temperatures in the surrounding air. A portion of the heat moves out rapidly and becomes blast and some of it is radiated as heat. Striking effects were produced by the amount of heat released upon the detonation of the atom bombs. In the Los Alamos experiments the heat generated by the atomic explosion crumpled the steel tower, melting it into a liquid. Polished granite building fronts, tombstones or ornamental columns and shrines of Hiroshima and Nagasaki were roughened or scaled by the heat and blast so that these objects looked much like those seen after sand blasting or roughening by pneumatic air hammers. Effects of this type were seen within a radius of one mile from the point of detonation of the bomb on the ground. Iron and steel structures were twisted, bent and melted by the intense heat. Wooden structures such as electrc light poles, buildings, and fences were charred by the heat. Evidences of this kind of charring were seen as far as 13,000 feet from the center of the bomb explosion.[10] One striking epsode occurred on a concrete and steel bridge with asphalt paving. A Japanese had been crossing the bridge at the time the bomb was detonated. A smooth area that was a silhouette of his body remained on the asphalt surface on contrast to the roughened and heat seared road. The roughened areas had been heated and etched by sand and debris, blown by the blast. Heat waves like blast travel outward from the point of origin in straight lines making it possible to determine the exact point of detonation of the bomb. The Jap's body had served as a shield to absorb the intense heat in the silhouetted area.

Probably few initial fires started as the result of the flash. A number of secondary fires were caused by blast effects that carried hot and burning objects which kindled satellite fires. Even if there had been sufficient fire fighting equipment available it is doubtful that it would have been able to cope with the thousands of fires. Blast accentuated the damage done by fire alone. In many instances buildings were blown open by the blast thus exposing structures that otherwise would not have been set afire. Some fireproofed structures were gutted and exposed remaining flammable materials to be consumed in secondary fires.

Many persons received deep thermal burns. Clothing absorbed or reflected heat depending upon the nature and color of the material. Colored or black cloth absorbed heat and caused burns, while white clothing worn by people reflected the heat. Heat waves travel at the speed of light. Exposures to intense heat for a few thousandths of a second is enough to cause a burn. Dr. Warren Shields[14] described the protection afforded the asphalt bridge, previously mentioned by the shadow of the concrete posts and side railings. Concrete side railings were sufficient to absorb the intense heat of the bomb at Hiroshima so that the asphalt was not melted over the areas of their shadows. Minor and severe burns were frequently encountered among the inhabitants of the two cities of Japan. Severe burns resulted in early death. A number of severe burns of the face and hands were encountered and ears were not infrequently burned off. Dark clothing and dark hair often absorbed enough heat to result in severe burns, even though the exposures were very short. A number of burn cases showed distinct margins indicative of the protective or harmful effect of clothing. Black cross straps worn over the white shirts of Japanese policemen frequently resulted in deep burns beneath the straps, that stood in sharp contrast to the remaining untouched skin over the back.

Secondary burns from flying missiles complicated the problems of medical care in Hiroshima and Nagasaki. It has been frequently reported that keloid formation was often encountered in the Japanese exposed to atomic heat.[9,4] A number of cases have been photographed and the formation of thick scars is grossly indicative of the burned areas. Keloids developed after severe initial burns and also after burns from flying missiles.

Light waves, of shorter length than heat waves, accompanied the explosions. Various reporters mentioned the orange yellow flash of the Hiroshima bomb and stated it was brilliant at 10 miles from the site of explosion. Dr. Stafford Warren in reporting the explosion at Bikini said that the flash was visible at 12 miles; in fact, at that distance the intensity of the flash was so great that it paralyzed the motion picture films leaving blank frames after development. Personnel exposed to atom bomb explosions were warned not to look at the detonation. No serious effects were reported from the light effects of the bombs.

Some of the devastating effects of the atom bomb are the result of its release of ionizing radiation. Blast and heat are both generated upon the detonation of high explosive bombs. Atom bombs are more severe as they are quantitatively more destructive and qualitatively they add the hazards of radiation exposure.

The atom bomb releases split or fission products, many of which are unstable isotopes which continue to emit beta particles and gamma rays in huge amounts. At first the activity of these isotopes is exceedingly high; however, since many of them have short half-lives they disappear rapidly. At the end of the first hour there is a steadily decreasing rate of intensity called the decay rate of the gamma rays. This intensity is inversely proportional to the time after detonation.[9] Depending upon the type of bomb used, the radioactive material is mixed either with the hot gases that rise as a plume over the bombed area or are contained in the water spray that is raised as a result of the underwater detonation.

Clouds from atom bombs that are exploded in the air rise rapidly above the earth into the stratosphere where they are a menace not only to the ground personnel, but could be dangerous to any planes that attempt to pass through them. The plume seen after the explosion containing debris, hot gases, and fission product that go up to 35,000 feet as in Test Able at Bikini.[14] Nitrogen in the air is ionized to form nitrous and nitric oxides. Clouds of radioactive material resulting from an aerial bomb may be dispersed to cover areas of approximately 150 miles in diameter. These clouds are at the mercy of the winds. Much of the dispersion depends upon the size of the particles, amount of water droplets available, and meterological conditions. Fine particles may be carried by high velocity wind currents for great distances to settle at unpredictable locations.[9]

Motion pictures of the Operations Crossroads explosions show at least three distinct phases of the detonation. First, a blank out of the pictures from the intense heat, second the white hot gases and then falling debris, or water. At first the cloud had a white or orange appearing material that cooled down after some time to red hot flames. In the third phase clouds were surrounded by darkened areas that represented silt, dust, and fine debris that had blown from neighboring areas. In Test Able a good deal of the silt had come from the various ships and included soot, rust, dirt, and the materials held in the harbor.

Motion picture studies of the second explosion at Bikini, taken 8 miles away showed clearly the sequence of events. It was estimated that 8 million gallons of water was raised in this explosion.[14] Fission products released by the bomb were absorbed in the water. The water mushroom was blown to such heights that the motion pictures recording the events took many feet of film recording the water spout. It was some time until the spout could be seen to fall.

Fission materials are really small particles that may adhere to dust or may be mixed with water droplets, hence radioactive clouds become a real problem. The rate of settling out of the mist is to a large extent determined by the size and composition of the particles and the effect of gravity on these particles. Neutrons, as they are broken off at the time of detonation, strike materials on the ground and in the water and contaminate these areas. Sodium, phosphorus and iron are readily attacked by radioactive split products. For example, in the Bikini Experiments it was found that ordinary soap, because of its sodium content, would retain neutrons and

carry significantly high quantities of radioactive material. Ordinarily, the neutron activity of aerial atom bombs on the ground below is not much of a hazard by the time that rescue squads or disaster personnel get in the area, because the half-lives of the radioactive materials are relatively short. After an underwater detonation, the situation is different. Water surrounding the atom bomb absorbs gamma radiation and neutrons contaminating the region, constituting problems of real concern. A large quantity of radioactive fission material is mixed with the water and is quite concentrated. When the water is thrown relatively high in the air by the force of the explosion the radioactive material, instead of being dispersed widely as in the case of aerial explosions, is more concentrated in a small area.

Conservative estimates conclude that the amount of fission material available in an underwater test as measured in gamma radiation, may be equivalent to that given off by tons of radium. Fish caught in the waters of the lagoon of Bikini had absorbed enough radioactive material that when held against sensitive paper they made autoroentgenograms. In other words, the fish made its own imprint from its own radioactivity.[14]

The effects of gamma radiation are well known and were frequently observed in Japan. All cells of the body showed gradual change including deranged or depressed function, an absence of reparative functioning tissue and death. It is, of course, difficult to separate the patients who have been exposed to radiation only from those who were also exposed to blast, heat and ionizing radiation. Survivors from blast and heat inside heavy concrete structures might be killed from the gamma radiation or by neutrons. On the other hand, the well known effects skipping occur and it is possible that certain persons who might have escaped death from radiation could have been killed by the effects of the blast or heat, or both.

Radiation sickness follows a well known pattern. After exposure to large doses of radioactive energy patients may die within a day or two before microscopic tissue changes are apparent. The immediate effects include weakness, vomiting, malaise, prostration and death within 48 hours. Gamma rays injure living tissue by ionization. Experimental animals exposed at Test Able that were first to die from radiation showed atrophy of the lymphoid tissue and frequently some ulceration of the tonsils.[15] Animals that survived a few days longer had hemorrhages, severe enteritis often so marked that there was complete necrosis of the intestinal mucosa and submucosa. In Hiroshima and at Nagasaki loss of hair occurred to many persons exposed to considerable gamma radiation. Many of the seriously ill had complete epilation of the scalp. This would began within a few days to three weeks after the exposure. Loss of hair was a serious prognostic sign, almost all patients who showed this sign subsequently died.

Delayed effects of radiation sickness are variable. From the second to the tenth day there is a rapid disintegration in the intestinal mucosa, accompanied by diarrhea and a large amount of blood lost in the stools. Later, there is fall in blood pressure, a leucopenia, and fever in the last few hours of life. From the second to the sixth week, intestinal injury is usually less marked and depression of the blood forming centers becomes evident. Clinical symptoms are few and may be no more than a transient nausea or some discomfort and weakness. The hematologic picture is more significant, often diagnostic. Disappearance of leucocytes from the blood are followed by infections about the mouth, gums or tonsils. Occasionally, Ludwig's Angina is a fatal complication. With severe leucopenia many patients die within three weeks from the onset of the exposure.

A group lived from three to five weeks after the exposure at Hiroshima and thrombocytopenia was the common cause of death. There was a gradual decrease of platelets and finally the blood failed to clot. Hemorrhages developed in the skin throughout the body or in the mucous membranes and secondary infection occurred about the mouth with a resultant fever. Purpuric lesions, mucosal and serosal lesions were found in the bodies of those who died. While there was some variation in the size of skin lesions from multiple petechia to large purpura, the mucosal lesions were widespread and severe.

Another group of patients had an almost complete suppression of the activities of the bone marrow and hemopoietic centers. Within a few days neither white cells, red cells or platelets appeared in the circulating blood, in fact only histocytes made up the blood stream. Cases of

this type were all uniformly fatal. About 15 per cent of the animals used in Test Able were killed by radiation and exhibited these changes. Attempts have been made to repeatedly transfuse animals that received large doses of radiation and showed depression of the bone marrow. Latest reports indicate repeated transfusions keep the animals alive but have not resulted in regeneration of the bone marrow.[15]

Delayed effects on the sex glands has been noted. A group of high school girls exposed to the Hiroshima bomb have had suppressed or delayed menses. The effects on male gonads are more striking. Sterility is evident and reports of testicular atrophy well substantiated.[16] The whole question of delayed genetic changes is under investigation at present.

To meet the many and complex problems of atom bomb casualties, a comprehensive and detailed program of medical care is necessary. The American Medical Association became concerned with the situation and the House of Delegates in December, 1945, directed a study of the overall needs and utilization of medical skills and resources of the nation in the event of a national emergency. A Committee on National Military Service was appointed and began its work on March 19, 1946, at the request of the committee, the Executive Committee of the Board of Trustees changed the name to the committee on National Emergency Service.

Conferences were held with leaders in government relative to future planning to meet national emergencies. Letters were sent to 400 key men in positions of civilian and military leadership. A lengthy questionnaire was sent to former medical officers to ascertain their opinions concerning utilization and training of physicians in future emergencies and related subjects. Consideration was given to new types of warfare including atom bombs, guided missiles, bacterial, chemical and psychological means.

A report of the activities of the Committee on National Emergency Medical Service was made to the House of Delegates in Atlantic City in June, 1947. It was emphasized that the problems before the Committee were many and they should be continuously studied as new developments were being made in the fields of technology daily. It was recommended to the House of Delegates on June 9, 1947, that the Committee be discharged and a Council be created within the Association to carry out important studies of the medical problems of a national emergency.

The House of Delegates dissolved the Committee and authorized the creation of a Council on National Emergency Medical Service as a standing committee of the Board of Trustees. At a meeting of the Board of Trustees on September 4, 1947, a Council of seven members was appointed to continue the work of studying the best utilization of medical service during a national emergency. The Council at its several meetings has effected a sound organization, a statement of the problems facing it, and the recognition that it will require the active cooperation and assistance of state and county medical societies. Letters were sent to the state medical societies requesting them to appoint committees on national emergency medical service.

The Illinois Medical Society through its Council took prompt action by adding the duties of national emergency medical service to its standing committee on veterans affairs. The name of the committee has been changed to The Committee on Military Affairs and Emergency Medical Service. Together, I am certain that we can develop plans that will help meet realistically the medical care problems of an atomic age.

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The Clinical Application of the RH Factor

E. T. McEnery, M.D., G. R. Baba, M.D. and K. Togasaki, M.D.
Chicago

In presenting this paper, I do not intend to discuss the laboratory details or the unusual situations arising in reference to the Rh factor but to present to you a clinical evaluation of the subject in observing the workings of this new and important problem in a large obstetric and newborn service.

During the past five years the Rh factor has been discussed and written about very extensively. Some of the writings have been very clear and others have added confusion to the subject. To try and answer some of the questions regarding the Rh Factor it was decided to run Rh determinations on every patient coming to Lewis Memorial Maternity Clinic. This was started in October 1944.

The questions that we wished to answer are these:

What was the incidence of the Rh negative woman in our clinic?

Could an Rh negative mother have a normal child and if so how many?

What was the parity of the Rh negative mother?

How many babies delivered of Rh negative mothers developed complications?

What plan could be followed, to give us some clinical evidence, whether or not an infant delivered of an Rh negative mother was developing erythroblastosis?

What treatment could be given these babies, who developed erythroblastosis?

Was there any way we could foretell the possibility of trouble with an infant to be delivered of an Rh negative mother?

What would these infants delivered of an Rh negative mother show on a mental and physical check up one year after delivery?

TABLE NO. 1

Number of Mothers delivered and tested	2,372
Number of RH Negative Mothers delivered ..	223
Number of Mothers delivered Babies developed complications	12

Gravida of RH Mothers delivered

1	2	3	4	5	6	7	13
59	70	46	20	16	8	3	1

Complications occurred 12 cases Gravida

2	3	4	6
2	4	4	2

All babies with complications — RH Positive.
All Fathers of these babies were RH Positive.
Sex of Babies delivered RH Negative Mothers

Male—103, Female—120

Sex of Babies Developing Complications

	Male	Female
Erythroblastosis	8	1
Hydrops	2	1

Method used in Rh determinations. In the beginning of this series, we used rabbit serum for testing but found that it was not as accurate as human serum. We now use the test tube method with incubation, as described by Weiner. This is both a macroscopic and microscopic test.

The number of women delivered and tested from Oct. 1944 to Dec. 1946, were 2372, of these 223 gave Rh negative reactions. Of these 223

Read before the Joint Sessions of the Sections on Pediatrics and Gynecology & Obstetrics, 107th Annual Meeting Illinois State Medical Society, May 13, 1947.

mothers delivered 12 babies developed complications. The gravida of the mothers delivered is listed in table 1.

The 12 babies delivered of Rh negative mothers, who developed complications occurred in the following pregnancies: 2 in the second, 4 in the third, 4 in the fourth, and 2 in the sixth. This again confirms the finding that complications seldom develop in the first pregnancy, unless previous sensitization has been produced by transfusion of Rh positive blood.

All of the babies, who developed complications were Rh positive. All of the fathers of these babies were Rh positive. The sex of the babies delivered of Rh negative mothers were: male 103 and female 120. The sex of the babies developing complications: erythroblastosis, male 8, female 1; fetal hydrops, male 2, female 1.

While this data on the Rh factor was being accumulated, the babies of these Rh negative mothers were being delivered and we never knew what to expect of these babies. We examined them frequently, noting if any icterus was present. or if the liver and spleen were palpable. We then began to realize that many of the babies of the Rh negative mothers were normal infants. In fact at one time in the nursery, there were ten babies of Rh negative mothers and they were all normal.

Clinically it was difficult to tell when one of these babies were developing any complications. To aid us in this clinical evaluation, we developed a routine procedure on all babies delivered of Rh negative mothers. Complete blood counts were made on the second day together with the Rh factor and blood group of the child. In the differential count, attention was directed to the presence of normoblasts. If these were increasing and the R.B.C. were dropping, plans for a transfusion of Rh negative compatible blood was made. As an added precaution that babies of Rh negative mothers should be watched closely, a special blood laboratory sheet is placed on the babies chart when it comes from the delivery room. On this sheet is a report of the mothers blood work, which includes the Rh factor, blood group, agglutination titer and blocking body study. A special card is placed at the head of the babies crib to let all in the nursery know that this baby should be given special attention, during its first few days of life.

The indications for giving blood transfusions were, increasing icterus, R.B.C. dropping below three million, increase in the number of normoblasts and enlargement of liver and spleen. If blood transfusions were given we always used Rh negative blood. Transfusions amounted to 50-75cc every second or third day and usually three transfusions were sufficient.

CASE HISTORIES OF PATIENTS DEVELOPING COMPLICATIONS

Case 1 (M) 28 yr. Para 3. Icteric at birth. Two previous pregnancies normal. Rbc second day 2,590,000 Hb 54% Normoblasts 56%. Liver and spleen palpable. Given three transfusions. Baby recovered. Examined at end of first year-normal.

Case 2 (M) 38 yr. Para 2. First pregnancy normal in May 1940. In Dec. Mother received two transfusions following sepsis possibly Rh positive blood. Infant severe icterus at birth. Liver and spleen palpable. Rbc second day 3,200,000 Normoblasts 23%. Baby given two transfusions, recovered. Normal at 1 yr.

Case 3 (G) Para 3. First two pregnancies normal. Infant marked icterus at birth. Rbc. second day 6,000,000 Normoblasts 37%. Rbc. fourth day 2,400,000 Normoblasts 23%. Baby given two transfusions. Normal baby at 1 yr.

Case 4 (M) Age 38. Five previous pregnancies all normal. Sixth pregnancy — macerated fetus. Post mortem fetal hydrops.

Case 5 (M) Age 38 yrs. First pregnancy normal infant. Second baby (Case 2) Third pregnancy — two month premature infant fetal hydrops.

Case 6 (A) 25 yr. First three pregnancies normal. Fourth and fifth pregnancies abortions. Sixth pregnancy — baby developed marked icterus second day. Rbc. 4,610,000 second day. Normoblasts 4%. Rbc. 3,600,000 sixth day. Normoblasts 10%. Liver and spleen palpable. Three transfusions. Baby normal at 1 yr.

Case 7 (C) Age 24. Two previous pregnancies normal. Third pregnancy marked icterus at birth. Spleen and liver palpable. Rbc. 3,002,000 second day. Normoblasts 80%. Rbc. 2,820,000 third day. Normoblasts 60%. Transfusion three. Baby normal at 1 yr.

Case 8 (G) Age 42. Three previous pregnancies normal. Fourth pregnancy marked icteric infant. Liver and spleen palpable. Rbc. 3,000,000 fourth day. Normoblasts 10%. Rbc. 2,300,000 fifth day. Normoblasts 15%. Transfusion 100cc Packed Rbc three times. Blood count after these transfusions 3,600,000. Then given two transfusions of Rh negative blood. Baby normal at 1 yr.

Case 9 (S) Age 27. Three previous normal pregnancies. Fourth baby normal for two days then developed marked icterus. Liver and spleen palpable. Rbc 3,500,000 third day. Normoblasts 15%. Developed marked opisthotonus, convulsions. Baby recovered after three transfusions Rh negative blood.

Case 10 (S) Age 21. First pregnancy normal. Second and third abortions. Mother had transfusion after first

pregnancy Rh positive blood. Fourth pregnancy baby developed severe icterus second day. Rbc. 3,200,000 second day. Baby died same day. PM showed findings of erythroblastosis.

Case 11 (C) Age 29. First two pregnancies normal. Third pregnancy baby died first day no PM. Fourth pregnancy baby icteric at birth, yellow vernix. Liver recovered.

Case 12 (M) First pregnancy normal. Mother in 1941 had a kidney operation received five transfusions. Rh positive blood. Gained twenty pounds during second trimester. Blocking bodies present. Dr. Davidshon reported trouble ahead. At seven months delivered a macerated foetus. PM showed Erythroblastosis.

In three of the above cases the mothers had received blood transfusions of possible Rh positive blood. These cases should act as a warning, that all women receiving blood, their Rh factor should be known. This warning holds good for children, because if Rh positive blood is given to any female whose Rh factor is negative it sensatizes that female to the Rh positive factor and this will cause trouble in years to come if she becomes pregnant. The giving of intramuscular blood to small infants, should be abandoned because of this same reason.

Clinically it was felt that we could recognize a baby of an Rh negative mother who was developing complications. Sometimes this clinical picture presented itself even though the Rh factor on the mother was positive. Sometimes on re-checking this determination it was found to be negative. Regardless of the laboratory report one should always be guided clinically by the condition of the baby. One is always safe in giving a transfusion of Rh negative blood.

In this study we were interested to know if some of these complications could not be predicted before delivery. Since Feb. 1946 we have run not only the Rh factor but on all Rh negative women, a study has been made on the agglutination titer and the presence of blocking bodies during the last two trimesters. This work has been done through the cooperation of Dr. Davidshon in his laboratory. If the titers are high and the blocking bodies are present trouble is ahead. A case history will illustrate this point.

Case (M) Aged 27. Para 2 First pregnancy normal. After first pregnancy Mother received several transfusions (Rh blood.) The blood was drawn from this mother during the second trimester, for agglutination titer and blocking antibodies study. Dr. Davidshon reported the following. "Fairly strong blocking antibodies and some conglutinating antibodies, but no regular anti Rh agglutins. This finding was interpreted as a sign of rather marked sensitization to the Rh factor and indicative of trouble in case of pregnancy." One month later, this woman delivered a six month gestation fetus with a clinical diagnosis of Polyhydraminos.

Our interest in what these babies of Rh negative mothers would show at the end of their first year was stimulated by an article in the AMA Journal by Dr. Yanette, in which he brought out the fact that the incidence of the Rh negative mother was higher in a group of non-classified mental defective children. We felt that it would be worth our while to check on our group. Even though we had watched these infants very closely we were anxious to see if we had missed any complications during their stay in the hospital for two weeks. Requests have been sent out to sixty cases and we have examined fifty-eight. We have only found one congenital defect, unilateral congenital cateract. Physically and mentally they have all appeared normal. Two of these children treated for erythroblastosis have green staining on their teeth. Six of the children treated for erythroblastosis have reached one year and these have appeared normal mentally and physically.

From this study of the Rh Factor we feel that the subject is of great importance to the obstetrician and the pediatrician. Primarily to the obstetrician because he can start the proper care of the patient. Secondarily to the Pediatrician because he cares for the infant after delivery, watches for complications and institutes treatment. We feel that a definite plan should be followed in all hospitals, which would make for better care of the mother and infant.
We would recommend the following plan:

All pregnant women should have Rh tests performed.

All Rh negative women should have agglutination titers and blocking antibody studies made every trimester.

If agglutination titers are high and blocking bodies are present trouble will usually develop in the baby.

All babies delivered of Rh negative mothers should have Rh factor determination run after birth, together with blood grouping and a complete blood count on the first-second-fourth and sixth days. If blood count is drop-

ping below three million. Transfusion of Rh negative blood should be given.

All babies delivered of Rh negative mothers should have a complete physical and mental examination at the end of the first year.

SUMMARY

The Rh factor problem is not completely solved. We should look at it with an open mind because reports are coming in from all parts of the country and our ideas will have to change.

We feel that by following these fundamental clinical and laboratory principles and suggestions, that many difficulties will be avoided and many infants saved.

DISCUSSION

Dr. Israel Davidsohn, Chicago: Dr. McEnery's paper contains a great deal of very valuable information. I hope it will dispel the misconceptions regarding the Rh factor and its application in clinical medicine. I would like to emphasize a few points.

We are almost completely helpless when it comes to attempts to prevent total erythroblastosis, with the possible exception of those occasional cases occurring in the first child, because as Dr. McEnery pointed out, the disease is rare in the first child. In the majority of cases in which the disease has been studied it has been found that the mother of the baby had a transfusion some time in the past. Therefore, the recommendation by Dr. McEnery that every female patient, regardless of age, should have the Rh factor determined before she is the recipient of blood and then given Rh negative blood if found to be Rh negative. It used to be said that Rh negative individuals receiving Rh positive blood will not become sensitized except in the ratio of one in 30. Recent studies on material in the Army and Navy show that sensitization is nearer to 50 per cent.

In the treatment of fetal erythroblastosis it seems to me that the time factor is the most important single item, that is, to waste as little time as possible after the baby is born in determining that the baby needs blood. This saving of time should begin at the moment it is found that the woman is pregnant; in other words, she should have the Rh factor determined and if she is Rh negative, then the Rh factor of the husband should be determined. One should determine the Rh antibodies during pregnancy and I recommend that it should be done sooner than three months after conception. While it is true that if we find Rh antibodies in the woman we may find them in the baby. There are exceptions. Not infrequently the antibodies remain from the previous pregnancy. In multiparous women the antibodies often persist for many years. In a case I have under observation it is now four and one-half years and the antibodies are still there in sizable titer. If we find these antibodies in the second or third month of pregnancy it is not likely that they are due to the pregnancy but are from a previous pregnancy. Then the interpretation must be something different.

Another thing is to determine whether the husband is homozygous Rh negative. That can be done in one of two ways. We do an Rh factor on his parents and on any of his living children. If any of them are found to be Rh negative, then he is Rh positive heterozygous and there is a fifty per cent chance that a baby born will be Rh negative. The other way is a little more difficult. Anti-Rh serum is tested and if agglutination occurs that individual is heterozygous. If there is no clotting with that serum it is a definite fact that he is heterozygous and all his children will be Rh positive and very likely affected with the disease.

We have another test that is important if we want to know whether the baby will have complications. Everybody should do two titers on the blood count. As shown by Dr. McEnery, the baby may be born with a normal count and then in two or three days the count will drop. If we can determine that the baby is going to be sick at the time it is born, then we can institute treatment earlier. This test was first done by Dr. Coombs of England. The test shows that the red cells are coated with antibodies and one can determine this by using immune serum injected into rabbits. This test done on the blood of the newborn baby tells us immediately if the baby is going to show manifestations of the disease even if no manifestations are present at the time of birth.

I am of the opinion that the so-called exsanguination or exchange transfusion constitutes a very great improvement in the treatment. I am basing it mostly on the experience of others who have done a number of cases. My own experience is limited to two cases. This procedure is based on the withdrawal of blood from the baby and replacing that blood with Rh negative blood. The operation is very simple if one follows Dr. Diamond's technic of using umbilical blood. If one replaces approximately two-thirds of the blood with new blood and adds about 100 c.c. of other blood, one is very much impressed with the results. That is all we need, no more transfusions were necessary in the two cases I had.

I would like to add that we have at the present time tests which determine the sensitization of the mother in almost 100 per cent of the instances. Including the regular tests for antibodies and serum-albumin agglutination one can determine the presence of sensitization in approximately 98 per cent of the cases.

Conservative Obstetrics

Ernest E. Davis, M.D.

Avon

This paper is a review of the current literature on this subject. While not intending to quote verbatim many authorities every effort is made to give credit where it is due. The fact is well known that more than 90% of all cases of pregnancy will terminate normally if left to nature and guarded aseptically. More than 50% of all deliveries are made by the general practitioner. Many of these men are giving so little time to their obstetrical cases that they might be accused of practicing reckless obstetrics. Practically all specially trained obstetricians advocate and practice what is to them conservative obstetrics and their methods in the hands of the general practitioner might well be radical procedures. The well trained man will have as keen a mind for contraindications as for indications and has the subject so well in hand that by his strategy he brings the largest number of cases to a successful termination.

Being born is a hazardous occupation but the rate the hazard is being reduced is indeed gratifying. The death rate for children under one year of age dropped from 99.9 per one thousand live births in 1915 to 48.7 in 1940. To further this reduction better co-operation is urged between the obstetricians and the pediatricians. In fact, the pediatricians feel that they have a little the edge on the obstetricians because the death rate for children under one year has improved so much more than for children under one month. The Chicago Health Department in co-operation with the hospitals and physicians instituted a program which reduced the neonatal death rates in Chicago to less than one-half what it is in the United States as a whole. Many other cities have accomplished similar results. Many state medical societies through their maternal welfare and child hygiene programs have aroused an interest in and started a work which will show marvelous results in the next five years. Nebraska reduced neo-natal mortality from 1331 deaths in 1930 to 764 in 1941. Cruickshank found that 67.5% of children dying at birth or soon after died of asphyia, birth injury or prematurity, 28.7% died of infections, 2.7% of developmental abnormalities and less than 1% of syphilis.

Tyson of Philadelphia tells us that autopsies proved that twice as many babies died of infection as was formerly thought, that the child born of slow birth died of infection while the child born of quick birth died of trauma. Dr. John Parks of Washington D.C. suggested that giving the mothers sulfonamides in prolonged labors may prevent some of these deaths from infection.

Sage of Omaha feels that giving vitamin K routinely may prevent cerebral hemorrage in some prematures, and that all analgesics and anaesthetics should be avoided in the delivery of the premature infant.

Conservative obstetrics is such management of both pregnancy and labor as will best conserve the health of both mother and child. It has taken the general practitioner a long time to realize how important a part adequate prenatal care plays in the successful termination of pregnancy. Then if prenatal care is really adequate the test of labor is rarely needed and eclampsia is reduced to a minimum. On the bases of cephalo pelvic relationship the type of delivery should be determined before labor begins. Adequate prenatal care is a prerequisite of conservative obstetrics and cannot be over-emphasized. Doctors Ivy and Rudolph made a thorough study of the physiology of the uterus in pregnancy and labor. They find that during the first stage of labor the fetus remains relatively stationary, that effacement and dilatation of the cervix are brought about by the upper uterine segment contracting and thereby becoming shorter and thicker and pulling up on the cervix which stretches and becomes thinner. Finally when the

Presented before the Section on Obstetrics and Gynecology, 107th Annual Meeting of the Illinois State Medical Society, May 12-14, 1947.

first stage is completed the ridge of Bandl is obliterated and the uterine pull is transferred from the cervix to the bony pelvis through the fascia and the vaginal walls, which become taut and form a tapering uterovaginal canal. As the upper segment contracts it becomes shorter and the ovoid descends. At this time the bearing down process begins and with each good pain the uterine cavity becomes smaller.

In false labor pains the upper segment may contract and pain the patient, but does not thicken or retract. The lower segment does not dilate and the ring of Bandl does not rise. The normal progressive changes do not take place. This is the condition usually thought of as uterine inertia but Dr. Rudolph much prefers the term uterine dysfunction as the term more nearly expresses the physiologic change. This dysfunction may occur before labor as false labor pains or any time during labor. It may start and stop anytime, but in his opinion it is practically always a temporary condition. How well the uterus is functioning is determined by the amount of effacement and dilatation of the cervix and the descent of the presenting part. From my limited experience I thoroughly agree with Dr. Rudolph that many more of our dystocias are due to uterine dysfunction than to cephalo pelvic disproportion. He is quite right in his contention that the importance of the physiology of the uterus ras been badly neglected while cephalo pelvic disproportion has been greatly over emphasized.

Plass is authority for the statement that in the average white population of this country obstetrically significant contractions of the pelvic inlet probably do not exceed 1 or 2% and at least in one-half of these the child will be small enough to deliver through the vagina. (Plass and Rudolph both state, as every one will agree, that when a real and definite disproportion does exist an elective cesarean section should be done.) Plass states that the treatment of uterine dysfunction or inertia is maintaining water balance and nourishment plus sedation, plus intelligent, patient waiting.

The real exponant of conservatism in obstetrics is Richard Torpin of Augusta, Georgia, who bases his paper on the delivery of 6000 women about equally divided between white and negro and concludes that conservative methods proved more valuable than radical ones and that as a rule those benefiting the mother most were also best for the babe. He developed through the trial and error method a test of labor not too rigid and not too lenient in which 95% of cases would deliver spontaneously and which all patients could tolerate. The test is as follows: Uterine contractions lasting 40 seconds every 2 to 5 minutes over a period of 20 to 24 hours with noticeable progress. The patient is supported meanwhile with water dextrose vitamins, and oxygen if necessary, plus proper sedation. At the end of this test the vast majority of babies will have been born, others in mid-pelvis and can be delivered by forceps, and still a few with the head still floating can be delivered by low extra-peritioneal cesarean section. Following this test carefully along with clinical judgment operative deliveries can be reduced to about 3%. Of these about 2½% will be forceps deliveries and ½ of 1% cesarean sections. Version and extraction is limited to transverse presentations. Progress is determined by rectal examinations, vaginal examinations are not done. An antiseptic solution is injected into the vagina every four hours during labor to prevent infection.

Exhaustion of either mother or child is watched for and progress of labor expressed in terms of effacement and dilatation of cervix and descent of presenting part. In most cases the patient is allowed to labor for at least 2 hours after full dilatation of cervix before applying forceps. In case the heart tones show any evidence of distress of the infant oxygen should be administered to the mother. The improvement in the fetal heart rate may be quite dramatic and may save the infants life. This is especially indicated in toxic patients.

Dr. Stewart H. Clifford of Boston remarks that the x-ray control of abnormal labor should be as required a procedure as is the use of x-rays in the treatment of fractures. Torpin is a zealous enthusiast on the use of x-ray in obstetrics. He advises a film made on all primaperas at 8 months and again on entering the hospital for delivery, and on multiperas if any complications develop. By this method the management of labor becomes a science as well as an art.

Torpin has a few time tried rules that are applicable —

1. Test of labor is given to all women who have an inlet anterior posterior diameter of 9 cm. or more, even if there is also some narrowing.

2. If inlet is less than 9 cm. selective section is done. However, most babies will deliver safely through a pelvis whose anterio-posterior inlet is above 8 if it is accompanied by a wide inlet. On the other hand it is astonishing how few women, colored or white other than dwarfs have inlets less than 9 cm. (Probably one or two in 1000). Frequently a babe will deliver normally whose biparietal diameter is equal to the anterio-posterior inlet diameter of the pelvis.

3. A narrow outlet as seen in the inlet grid film by noting the degree of inward protrusion of the ischial spines occasionally causes dystocia, especially if the occiput presents posteriorally. The spines hold the head and prevent its rotation. Half of the infants delivering direct occiput posterior had this as an etiologic factor.

4. If the placenta is on the anterior wall of the uterus there is increased chance for the fetus to present with the occiput posterior.

5. Induction of labor should have a valid indication.

6. Prophylactic external version should be done if the head is not presenting.

7. What helps the mother is usually aid to the fetus; in three words, water, sugar and oxygen.

8. Sedation of labor takes preference over stimulation.

9. When the cervix has been fully dilated two hours, delivery is quite safe if done by deep episiotomy and either Kristellar expression or low forceps.

10. Cesarean section does not reduce the mortality of the premature infant.

11. Vitamin K should be given routinely.

Dr. Louis Rudolph of Chicago tells us how to manage the prolonged first stage of labor when he reports on 69 cases at Cook County Hospital with no maternal deaths, 13 neo-natal deaths and one cesarean section. A labor is considered prolonged if after 18 hours of good pains the indications are that the patient will not deliver in another 10 hours. A patient may have periods of false and true uterine contractions from 30 to 100 hours before reaching the second stage. Dr. Rudolph says the patient should be advised in advance of the possibility of prolonged first stage of labor, and that she and the family should be assured during labor that everything is normal except the uterus is functioning slowly.

The first step in the proper management of the case of prolonged first stage of labor is a comprehensive, accurate and positive diagnosis of the cephalo pelvic relation, position of the presenting part and the physical and mental state of the patient. This diagnosis is not constant and may change anytime. The dystocia of prolonged first stage of labor may be either mechanical or functional or both. The mechanical may be either absolute or border-line. The absolute requires cesarean section. The border-line may or may not according to the findings and the judgment of the operator. If he decides to deliver from below he has ruled out cesarean section according to Dr. Rudolph. In actual practice, since the use of sulfonamides and penicillin, many operators do sections after attempts at delivery from below have been made. The section is done and the drugs started at once. Many physicians give sulfa or penicillin following every difficult delivery. Faith in these drugs should never at anytime permit any laxity in the aseptic management of labor, or carelessness in diagnosis.

Rudolph says we do not know the cause of the onset of labor or the regulatory mechanism of the uterus during labor, so we have no real active treatment of functional dystocia except intelligent watchful expectancy and the prevention of maternal exhaustion. Dr. Rudolph feeds the patient every four hours 3000 calories in 24 hours with enough sedation to ensure 8 hours rest in 24 hours. He uses morphine ¼; scopolamine 1/150 and repeats the scopolamine 1/200 in 45 minutes and again in 90 minutes. His idea of test of labor is to note the progess for a few hours beginning with the second stage of labor.

The best short formula for good conservative obstetrics is a zealous level headed obstetrician and a co-operative patient. When the actual condition is clearly understood, skillful and timely intervention may be far more conservative than non-operative procedure. This is so aptly illustrated by one of my own cases that I can not refrain from mentioning it. Many years ago a primapera 41 years old went into labor by spontaneous rupture of the membranes.

I waited 72 hours for pains to really do something. Then my consultant suggested we wait another 24 hours. We waited 12 hours and did a section. The mother weathered a rather stormy puerperium and recovered but we lost the twin boys. X-ray was not used in obstetrics at that time. Some 25 years later I had another primapera 37 years old go into labor by spontaneous rupture of membranes. I told this patient's mother that cesarean section must be considered. In less than three hours from the time the membranes ruptured the patient delivered twins by breech. More definite knowledge of the conditions present in the first case would have prompted early section and should have saved the babies. Whether they died of infection or cerebral hemorrhage I do not know but probably of infection.

Practically all authorities are agreed, little or no analgesics or anaesthetics should be used in the delivery of the premature infant. Yet all are unanamiously agreed that both should be used freely and with judgment in the delivery of the full term child, each operator choosing and using the one best adapted to his liking and the particular case in hand. Continuous caudal anaesthesia was thought to be the full answer to this prayer, but most every one will agree with Dr. Sage of Omaha that, "It is just as good as the one who gives it." It requires both technical skill and institutional supervision. Dr. Danforth feels that deep ether is the best anaesthesic for all intrauterine manipulations and that it works quicker and safer if preceded by sytemic analgesia than by caudal anaesthesia.

Dr. Potter points out that the death rate for children delivered by version and extraction is 1 in 25, for delivery by high forceps 1 in 33, for breech delivery 1 in 50, for cesarean section 1 in 110, for low forceps 1 in 330, for natural cephalic delivery 1 in 500. Dr. Potter also adds that in breech deliveries more bad results come from attempting to deliver through an undilated cervix than from any other cause.

The most advanced conservative measures I noticed in the literature were three advocated by Dr. N. J. Eastman of Baltimore. 1. That the bag of waters being no longer considered an essential factor in the dilatation of the cervix, the rupture of the membranes is the best way to produce labor, this replacing the bougies and the Voorhees bag. This procedure has been so unanimously accepted that it has been abused. Too many times labor is induced ill advisedly. Formerly we were taught that early rupture of the membranes was the principal cause of uterine inertia or dysfunction. The two twin labors mentioned above illustrate the fact that different uteri function differently. The endocrinologist will have to explain why. 2. That pituitary extract can be used safely in minute doses, in case of inertia or dysfunction of the uterus. He feels that it reduced the incidence of difficult midforceps operations from ten or twelve a year to one or two, and Duhrssens incisions proportionally. This procedure has very great merit. I remember well being called to see a case over thirty years ago where the patient had been in labor more than 24 hours. It was her 14th pregnancy and she was having little pain, dilatation was complete and the head was floating above the pelvis. I did a very easy version and extraction with happy results. I firmly believe that by the use of a 2 mm dose of pituitary extract the patient would have delivered spontaneously. Of course, it must be used with caution and the operator must know that the conditions are right before giving it. Its promiscuous use to hurry a normal labor in doses greater than 2 mm is condemned as bad practice. Its use with castor oil to initiate labor may produce very happy results. 3. That if every woman at time of conception could be a healthy woman it would reduce maternal mortality by one-fourth, therefore he recommends that all women who have had eight or more children be sterilized, solely on the grounds of multi-parity, as a prophylactic measure.

Far be it from me to question the logic or judgment of a man of Dr. Eastman's standing and experience, but from my own experience this measure seems a little far-fetched. In my own small community I can name nine women who have borne twelve or more children and were in excellent health for years afterwards. I have never known of a serious obstetrical complication due solely to multi-parity.

All patients with tuberculosis, heart disease, and diabetes complicated by pregnancy should be seen and treated by a specialist in the field to which they belong. After all has been said and done the pertinent fact remains, that too many babies die in the first month of life. The re-

sponsibility of this condition rests with the physicians delivering the babies. Dr. Arnel, New Orleans, thinks one-half neo-natal deaths are preventable. If all babies could be delivered by a specially trained obstetrician in a modern, well-equipped maternity hospital and their care at once turned over to a pediatrician the results would approach perfection. As this is impossible the practical plan would be for every general practitioner doing any obstetrics at all to associate himself with a good obstetrician and when a problem arises either in pregnancy or in labor he consult with the obstetrician. Hope for improvement lies in better obstetrics by the general practitioner.

A modification of the educational program for hospital staff members as outlined by Dr. M. H. Miller of Detroit in the J.A.M.A., May 3. 1947, is suggested as helpful.

Phenylpyruvic Oligophrenia

(Report on 16 clinical cases and two autopsies)

Herman Josephy, M.D.
Chicago

The history of the condition which has the name "phenylpyruvic oligophrenia" or "phenylketonuria" is a rather short one. In 1934 Foelling[1] from Oslo discovered this type of mental deficiency and described it in a short paper which deserves to be called classic, like Huntington's famous paper on chorea. On a few pages a new and hitherto unknown condition is described; the essential clinical and genetic features are enumerated and the importance of the close connection between an error in metabolism and mental deficiency is emphasized. Several authors have elaborated later on this type of oligophrenia, especially Penrose[2] and Bates[3] from England, Jervis[4,5] from New York, who made the most extensive and intensive investigation, and lately Medlicott[6] from Australia. All of them have confirmed Foelling's observations rather than being able to add essential new facts. A number of studies on metabolism will be mentioned later.

Phenylpyruvic acid is a derivate of phenylalanine. The latter is one of the so-called essential aminoacids; that means, it is assumed that it is indispensable for normal metabolism and cannot be replaced by other aminoacids. If it is deaminized, phenlypyruvic acid is formed as an intermediate metabolite. Normally this is broken down completely to water and carbon dioxide, and never appears in the urine. It is found only in those cases which classify as phenylpyruvic oligophrenia.

The test for phenylpyruvic acid in the urine is very simple. A few drops of a 5% aqueous solution of ferric chloride are added to the specimen which should be acid, or, if alcaline, be acidified. Immediately a dark green color develops which is very characteristic, and this color fades to a pale yellowish green in 5 to 15 minutes. Foelling has determined the compound

From the Chicago State Hospital. The material was collected at The Lincoln State School and Colony, Lincoln, Ill. The author wants to thank Dr. W. W. Fox, Superintendent, and the Medical Staff for making this study possible.

Presented before the State Physicians' Ass'n., Ill. State Med. Soc. 107th Annual Meeting, Chicago, May 12-14, 1947.

giving this reaction with ferric chloride as phenylpyruvic acid. One may modify the test by extracting the urine with ethylether and using the extract. One can furthermore precipitate the substance and determine the melting point etc. All this, however, seems to be rather unnecessary as the simple addition of ferric chloride always gives a clear result.

Besides the phenylpyruvic acid the urine of the patients contains 1-phenylalanine. Studies on the metabolism of the latter have shown[7, 8, 9, 10, 11] that in phenylpyruvic oligophrenics the bloodlevel of phenylalanine is 15 to 40 mg. per 100 cc. as compared with zero for normal individuals. Phenylalanine is found in the cerebrospinal fluid too. The excretion of phenylpyruvic acid is "the natural consequence" of the accumulation of phenylalanine (Foelling, loco). Ingestion of protein, of phenylalanine, phenylpyruvic acid and phenyllactic acid increases the output of phenylpyruvic acid. Ingestion of other aminoacids does not influence the output. 0.5 to 1 gm phenylpyruvic acid are excreted per day in the urine of the affected individuals. There is a colorimetric quantitative method available for determination.

Two basic facts are important. The first is that all individuals who excrete it are feebleminded. In spite of very numerous examinations which have been performed by several investigators, never a person of normal mentality has been found positive. All those who have worked on this subject, agree about this point. Foelling found it and so did Jervis in a large series of tests. I too can confirm it. Neither the parents of phenylpyruvic oligophrenics nor their normal siblings give a positive reaction. Therefore the close connection between this error in metabolism and mental deficiency can be taken for granted. The term phenylpyruvic oligophrenia refers to a group of feebleminded individuals who have in common the excretion of phenylpyruvic acid and the defective metabolism of phenylalanine.

The second basic fact is, that these patients excrete the phenylpyruvic acid always. In other words, any urine specimen taken at any time will give a positive reaction, independent from the diet. As mentioned before, a high protein diet makes the reaction stronger. Blood and cerebrospinal fluid give a negative reaction with ferric chloride, although a trace may be found.

Phenylpyruvic oligophrenia is rare. Foelling collected ten cases. Bates in England found 3 cases among 2300 institutional inmates; that is about 0.13%. Penrose saw one case among 500 feebleminded. Jervis who made a very extensive study in the state of New York, found 42 among 8034 inmates, that is 0.522% and in second very large series 161 in 20,300, that is 0.8%. Medlicott had two cases among 190 mental defectives. Holt (Ford)[12] saw 5 cases among 1000 feebleminded, that is 0.5%. I found in Lincoln State School and Colony 16 cases. 13 of them were present among 4300 inmates when I made a survey, that is a percentage of 0.3%. As all phenylpyruvic oligophrenics are on the lower level of mentality, the percentage will be influenced by the number of high grade mental defectives admitted to a given institution. If I subtract from the Lincoln State School population the high grade defectives, I get a percentage of about 0.45, which is rather close to Jervis first and to Ford's figure.

Not much can be said about the racial distribution except that up to now no cases have been found among Hebrews and negroes.

Jervis found a definite preponderance of the female sex, namely 125 girls as compared with 88 boys. I found 11 girls to 5 boys.

My sixteen cases from Lincoln State School and Colony come from 13 families. That means there are three pairs of siblings, sister and sister or brother and sister. In one family is one not institutionalized sibling who suffers from the same condition like his two institutionalized sisters. This accumulation of several cases in one family has been observed by all authors. It suggests at the first view that one is dealing with a hereditary condition. Jervis has worked up his large material by all methods of modern research in heredity. He finds that there is no external factor which could be held responsible, as for instance age of the parents at the time of birth, order in birth, birthtrauma and so on and concludes that the occurrence of phenplpyruvic oligophrenia in families is in agreement with the conception that it is due to a rare single recessive autosomal gene.

In eleven of my sixteen cases no pertinent data are given about the age at which feebleminded was apparent. Mostly it was stated

that the mental retardation was noted "very early". However in five cases there is a definite history that the affected child was born normally and developed normally during the first months of life. Then the child fell acutely ill, had a "fever", a "pneumonia", a "sleeping sickness", or a "poliomyelitis" and when this acute disease was over, feeblemindedness was evident. In one case the parents said, that a baby girl was normal until the age of four months; at this time she had "pneumonia" and was seriously ill for two weeks. After that she was "never normal again". In another case a boy seemed to be normal until he was seven months old. He became very ill; he ran a high fever and had diarrhea for seventeen days; he slept a great deal and it was assumed that he might have "sleeping sickness" or "infantile paralysis". After this acute illness the child's head "hung loose" and he never recovered. Another of my cases had "meningitis". Two siblings were admitted with the history that they had had "poliomyelitis", one at the age of two and the other at the age of one year.

In one case only it was said that a child deteriorated acutely at a time when feebleminded-ness already was evident.

The clinical findings in my sixteen cases are as follows. All sixteen are fair haired, white blond to light brown. There is none with a dark complexion, inspite of the fact that one has a darkhaired Italian father and several darkhaired normal siblings and another one has two parents of Italian origin. The skin of all these patients is poorly pigmented and to some degree photosensitive. These characteristics of the physical habitus have been seen and reported by all authors; they seem to be connected with this type of mental deficiency.

Fourteen of my sixteen cases classify as low idiots. Thirteen have an I. Q. of 10 and below. Only two are on the imbecile level; one has an I. Q. of 30 and the other of 41. This too confirms the findings of other authors who all have found that the phenylpyruvic oligophrenics are mostly on the idiot level and that a few only are imbeciles. The highest I. Q. up to now reported is 50. It seems that none of the cases showed an appreciable deterioration after admission to an institution.

A certain number of the patients are epileptic. Five of my sixteen were subject to fits. Among them were two with phenylpyruvic siblings without convulsions. This seems to indicate that epilepsy is rather accidental.

No anomalies of the heart, of the lungs, of the abdominal organs, nor of the endocrine glands are present. Bloodcounts and differentials give normal figures.

As for the neurological status, it can be said that the first impression is that of an organic disorder. The phenylpyruvic idiots are restless and jerky; their gait is clumsy and gives the impression of some spasticity. Frequently the body is kept slightly bent and stooped, suggesting rigidity. On the other hand the examination of the reflexes and of the tonus reveals no pathology except of somewhat vivid tendon reflexes. The pupils are equal and react well. Opthalmoscopic examination shows a normal fundus.

Jervis, Bates, Penrose and Medlicott have assumed that the jerkiness and the stooped posture are signs of an extrapyramidal syndrome. Ford has objected: he thinks that the phenylpyruvic oligophrenics do not exhibit true spasticity nor true extrapyramidal symptoms. As to him they do not differ from other mental defectives at the same mental level and their behavior and attitude is the same as frequently found in low idiots. I agree with this opinion. Cases with a higher intelligence such as the above mentioned boy with an I. Q. of 41, do not exhibit any jerkiness nor any symptoms indicating an organic neurological disorder.

It is somewhat surprising that up to now only one report about the pathological anatomy of a phenylpyruvic oligophrenia has been published. Penrose[13] described in 1939 the autopsy findings upon a boy with phenylpyruvic oligophrenia who was idiotic and epileptic and died at the age of 9½ years. Nodes in the vagus, the phrenic and some other nerves were found which proved to be neurofibromata. The brain was normal upon gross examination. Anatomically the case was classified as neurofibromatosis. On account of this observation Penrose claims that there is a relation between Recklinghausen's disease and phenylpyruvic oligophrenia.

I have had the opportunity to perform autopsies upon two patients with phenylpyruvic oli-

gophrenia. Both were low idiots. One died from a pulmonary tuberculosis, the other from a pneumonia. In both cases the post-mortem findings upon all organs, except of the lungs, were negative for any gross pathology. The brain had a weight of 1200 gms and 1200 gms respectively and was well formed. None of the peripheral nerves, which I could examine, had any tumors and the same was true for the cauda equina. In both cases I made a rather careful microscopical examination of all organs and especially of the brain. There was no significant pathology whatsoever. I cannot agree with the conception that there is any true relationship between phenylpyruvic oligophrenia and Recklinghausen's disease. It may be added that neither I nor any other author found peripheral nerve tumors in phenylpyruvics. Furthermore none of the cases of Recklinghausen's disease which I examined at Lincoln State School gave a positive reaction for phenylpyruvic acid in the urine. Thus up to now one can only say that the methods available for microscopical examination do not reveal any morphological pathological changes.

A condition exhibiting the unique combination of an error in metabolism and feeblemindedness offers a large opportunity for speculation. The analogy to other errors in metabolism like alkaptonuria, tyrosinuria or cystinuria is obvious. However none of these conditions is connected with mental deficiency. Another rather far fetched analogy may be found to familial amaurotic idiocy.

A satisfactory explanation why defective metabolism of phenylalanine is always combined with a low grade mental deficiency has not yet been given. One could assume that the same rare gene carries the quality "feeblemindedness" and "error of metabolism." This is rather unlikely. One would expect that occasionally the hereditary qualities would split, that is one would expect cases of excretion of phenylpyruvic acid without oligophrenia.

The most acceptable theory seems to be that a primary error in metabolism leads secondarily to mental deficiency, in the same way as the lack of thyroid hormone causes feeblemindedness. Himrich and Fazekas[14] could demonstrate that utilization of sugar and oxygen by the brain of phenylpyruvic oligophrenics is diminished. This seems to fit into the pattern of a mental retardation caused by an error in metabolism. Unfortunately it is not yet known whether the excretion of phenylpyruvic acid precedes the mental retardation. Foelling saw a child with a positive urine "too young as to decide whether it was feebleminded or not." I mentioned before that in some cases mental retardation became evident after an acute illness. It seems to be worthwhile to follow this observation.

A test for phenylpyruvic acid should be standard procedure in all cases of mental deficiency. There is, of course, no cure for the feebleminded-ness, but there is ample reason to warn the parents of such children against having more offspring.

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DISCUSSION

Dr. M. K. Horwitt, Elgin: Occasionally some inspired or lucky laboratory worker finds an anomaly of metabolism which serves to inspire the biochemist and give him hope that this new tool will produce a method which will make it possible to obtain a great deal of information about normal and abnormal pathways of carbohydrate and protein metabolism; but in most cases and even where the story is as clear-cut as that which Dr. Josephy has just presented, the laboratory investi-

gator is doomed to disappointment by the paucity of the useful tissue chemistry which results from his labors.

It is quite obvious that we do not yet know sufficient about normal pathways of tissue nutrition to be able to fully appreciate these metabolic mistakes. These metabolic mistakes have been referred to as inborn errors of metabolism for many years now.

When we consider how easy it is to identify phenylpyruvic oligophrenia, cystinuria and alkaptonuria, one feels that in time many other errors of metabolism will be found. There should be many other errors which should not be as simple to find as these. It is also likely that the urinary manifestations of these disorders may only be secondary, incidental phenomena resulting from the action of the kidney on abnormally large amounts of the products being present in the blood and tissues of individuals having these errors of metabolism.

For example, when these oligophrenics are fed phenylpyruvic acid, they immediately convert it quantitatively to phenylalanine. Indeed phenylpyruvic acid has not been successfully demonstrated in the blood of these phenylpyruvic oligophrenias. Thus, we must draw the conclusion that the phenylalanine is deaminated by the kidney to form the phenylpyruvic acid, which is found in the urine. If then the phenylalanine in large amounts is the foreign substance in the blood and possibly in the tissue fluids, why and how is this essential amino acid, without which the ordinary individual cannot live—and certainly we must assume that it is also essential for the oligophrenic—and which is obviously being used for the growth of the tissue, contributing to the pathology found? And why is it so disabling when it is present in large amounts?

Perhaps it will be possible, as our knowledge of amino acid metabolism develops, to conceive a practical diet which is low in phenylalanine but adequate in everything else, and which when used may give us information about this disorder and a means of study and possibly alleviation of symptoms.

RADIOACTIVE PHOSPHORUS GIVES RELIEF TO VICTIMS OF LEUKEMIA

Complete body irradiation with radioactive phosphorus, P^{32}, can prolong the useful and comfortable life of a patient with chronic leukemia, according to an article in the March 6 issue of *The Journal of the American Medical Association.* P^{32} is now derived from ordinary sulfur subjected to neutron bombardment in the atomic pile, with sodium chloride added.

The article covers an 11-year study of 129 leukemic patients by John H. Lawrence, M.D., R. Lowry Dobson, M.D., B. V. A. Low-Beer, M.D., and Bruce R. Brown, M.D., from the Divisions of Medical Physics, Medicine and Radiology, University of California, Berkeley.

Leukemia is a fatal disease of the blood in which abnormally large numbers of white cells are found in the blood and bone marrow. No cure has yet been found, because no known treatment destroys all the leukemic cells without having an extremely adverse affect on normal cells. The writers nevertheless emphasize the fact that "many patients with chronic leukemia have many years of relatively comfortable life, and it is not possible to predict which patients these will be when they are first seen."

Before 1936 total irradiation with x-rays was used in an attempt to control the overproduction of white cells in leukemia. In 1936 is was shown experimentally that when radioactive phosphorus was injected into leukemic mice, its visible beams of energy lodged mainly in the bone marrow and soft tissues, where the leukemic cells are found. This tended to discourage the process of white-cell overproduction, at least temporarily. The advantages over x-ray seemed obvious, since the radiation dose concentrated less on normal tissues and more on diseased tissues.

Treatment of human patients with P^{32} was then begun. Total body irradiation was accomplished either through injecting P^{32} into the veins or by giving it orally. It was soon learned that the doses required to bring about a favorable response varied tremendously with the individual

patient, but that in no case could doses large enough to have a permanent effect on the progress of the disease be administered safely. Palliation was therefore the objective.

The doctors say that theirs is the first attempt to study end results in a large series of leukemic patients observed during the period 1934 to 1947. Their patients all received P^{32}—and, in some cases, x-ray treatment as well—at the Crocker Clinic or the University of California Hospital before March 1, 1946.

"There was no conscious attempt to select those patients who might respond most favorably," they write. "It is our impression that a larger percentage of this group were in a more advanced stage of the disease than one would observe on the average. About one half of the patients had received previous courses of x-ray therapy before referral here or were treated with x-ray by us prior to trial with P^{32}. Likewise, many of them had failed to respond to other forms of therapy and were in poor condition.

"The ages of this group of patients at onset of first symptoms varied from 10 to 71 years, the average being 40.3 years. The sex distribution was 57 per cent males (73 cases) and 43 per cent females (56 cases).

"Clinical improvement, with a feeling of increased well-being, improvement in the red cell count, decrease in size of the spleen, decreased perspiration, etc., are all evaluated, and as long as most of these various criteria tend in the right direction, therapy is withheld. There have been a number of patients who have required therapy only every six to nine months and a few who have required it as infrequently as every one or two years.

"In the total series of 129 patients, 21 are alive, and of these, 17 are alive four or more years after onset and two are alive nine or more years after onset. Thirty-three patients in this series have lived or are living five or more years after the onset of their symptoms.

"It is not possible to show any remarkable lengthening of life after irradiation therapy whether it be given by local or total body x-ray radiation, with P^{32} internally, or by a combination of these technics. It should be emphasized that although this study of irradiated patients demonstrates our inability to control this disease in all instances, nevertheless it does show that the major portion of life duration is useful.

"At the present time, the two definite advantages of P^{32} would seem to lie in the ease with which it provides generalized irradiation and the lack of any radiation sickness. It is hoped also that further work and the passage of time will show that comfortable life can be prolonged somewhat more than the present figures indicate.

"Although these studies indicate that P^{32} may be the best therapeutic agent in the treatment of chronic myelogenous leukemia, they also add further emphasis to the need for a search for methods other than irradiation for the ultimate control of this baffling disease."

"JUST ANOTHER SOCIETY"

"In many areas, the county medical society has become just another society." So declared Dr. Louis H. Bauer, A.M.A. Trustee and President of the Medical Society of the State of New York in a recent address. Medicine, Dr. Bauer pointed out, has become overorganized. Surgical societies, obstetrical, pediatric, general practice societies, and others have sprung up everywhere. In many places, this has reduced the interest in county society activities, lowered attendance at its meetings, and diminished the county society's influence in the community. Never before has there been a greater need for alert and powerful county medical societies. Never before has medicine been so deeply involved in the solution of community problems and the guidance of social forces.

The American Medical Association and The Medical Society of New Jersey depend ultimately for their effectiveness in any given community upon the influence of the county medical society in that community. The county medical society in turn depends for its power, its usefulness — its very life — upon *you*, the individual physician. Are you doing all you can to strengthen the arm and to forward the work of your county medical society?—*Membership News Letter, The Med. Soc. of New Jersey, July,* 1948.

THE 1948 ANNUAL MEETING

There were more than 3,000 registrants at the Annual Meeting at the Palmer House in Chicago on May 10, 11, 12. They found an unusually well organized program, interesting technical exhibits, and valuable scientific exhibits awaiting them.

An innovation at this meeting was the continuous showing of medical films in a special theatre. This feature was well received and will probably become a regular part of future meetings.

This picture story shows you some of the events and introduces you to new officers who will serve you during the coming year.



Above. Irving H. Neece, Decatur, the retiring president, hands the gavel to his successor, Percy E. Hopkins, Chicago. Dr. Hopkins promised a continuation of the ideals and efforts of his predecessors in the office.







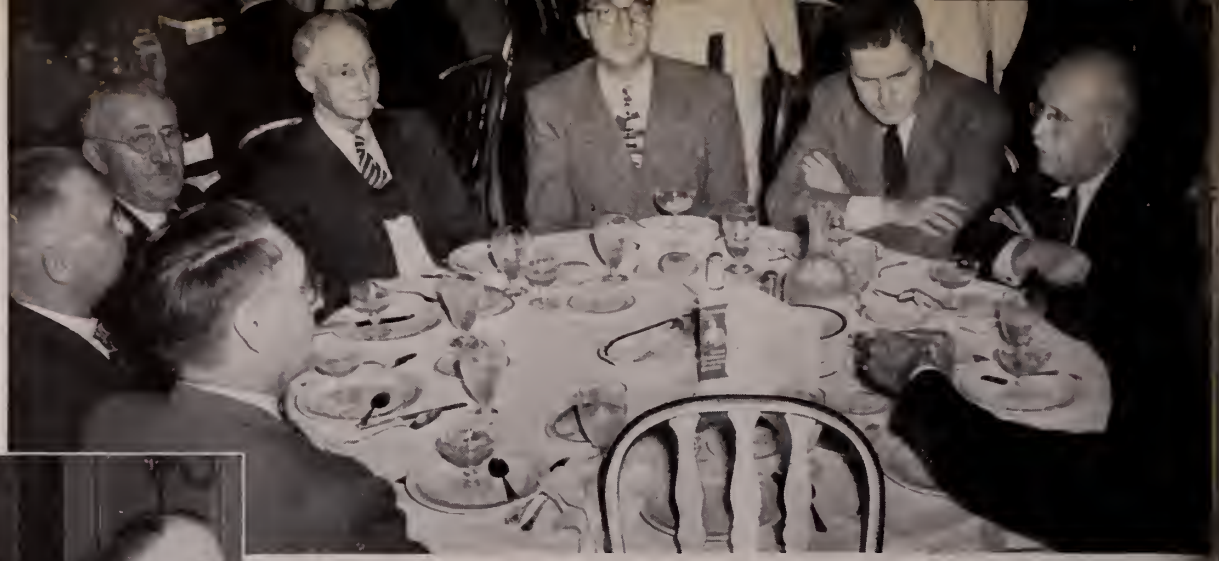
Four new councilors were elected at the meeting. Above, left. Joseph T. O'Neill, Ottawa, now represents the 2nd District. Center, F. L. Stone, Chicago, is one of the representatives for the 3rd District. Right. A. M. Vaughn, Chicago receives congratulations on being elected a 3rd District councilor. The 3rd District has six councilors.



Left. F. Garm Norbury, Jacksonville, is the new councilor for the 6th District.

Below. R. C. Oldfield, River Forest, chairman of the committee on arrangements for the Annual Meeting. He was elected 1st vice-president of the Society. At right, H. Kenneth Scatliff, Chicago, who served on the advisory committee for the meeting. The latter is now secretary of the Chicago Medical Society.







The Annual Dinner

The Annual Dinner was held in the Grand Ballroom. Above. D. M. Roberts, Alton, Roth, Chicago, P. H. Pechow, Kinderbrook, W. W. Kuntz, Barry, Bernard Chapman, Chicago, John Edgcomb, Joliet, J. H. Edgcomb, Ottawa, A. R. Whitefort, St. Elmo, and H. C. Turney, Shelbyville.

Left. Walter Stevenson, Quincy, who was chairman of the council and is now president-elect, with Dr. Franklin Bliss Snyder, president, Northwestern University. The latter spoke on "Business and Higher Education."



Right. Percy E. Hopkins discusses plans for the coming year with Mrs. L. N. Hamm, Lincoln, the new president of the Woman's Auxiliary.

Below. A gay party at the dinner includes Albert Nehf, and Mrs. Nehf, Kankakee, Miss Ann Barnstable, Waukegan, C. M. Fleming, Rushville, W. C. Bornemeier and Mrs. Bornemeier, Chicago, Mrs. Hayes, Chicago, Paul H. Anthony and Mrs. Anthony, Kankakee.





At The Beer Party







The Beer Party drew a large crowd and the strolling musicians and the antics of Marvin Himmel drew generous applause. Among those pictured are (top) E. S. Hamilton and Mrs. Hamilton, Kankakee, Andy Hall, Mt. Vernon, Mather Pfeiffenberger, Alton, and E. F. Moore, Collinsville, secretary of the Madison County Society. Bottom, right. Frank Deneen, Bloomington, Harold C. Lueth, Dean of University of Nebraska College of Medicine, E. H. Blair, M. M. Hoeltgen, vice-chairman of the committee on arrangements, Fred H. Muller, 2nd vice-president, and R. C. Oldfield, all of Chicago.

Below. Walter W. Murfin and Maurice D. Murfin, brothers from Decatur. The latter is secretary of the Macon County Society, and secretary for the Secretary's Conference dinner at the meeting.

Below. The Annual 50 Year Club Luncheon brought out many of its members. Among those pictured are H. O. Munson, Rushville, J. S. Geen, Utica, Joseph De Silva, Rock Island, Ralph H. Wheeler, Chicago, Sandor Horwitz, Peoria, H. O. Williams, Centralia, F. M. Edwards, Centralia, and A. A. Knapp, Peoria.





Luncheon Meetings





At the Medical Economics Committee Luncheon. Above. Chauncey C. Maher, chairman and Edwin F. Hirsch, Chicago. Right. Hubert Allen Jr., Alton, Edwin F. Baker, Lewistown, and Marie Wessels, Chicago.



Loyola University Alumni held a luncheon meeting. Left. George A. Hellmuth, Rev. G. G. Grant, S.J., Gertrude M. Engbring, Edward A. Piszczek and Robert E. Lee read a telegram from a well wisher.

The council met at lunch each day of the meeting. Below. Ralph P. Pears, L. J. Hughes, C. H. Hulick and Harry M. Hedge. The latter was named chairman of the council at this meeting.



Below. Diplomates of the National Board of Medical Examiners luncheon. Second from left, Willard O. Thompson, J. J. Moore, G. Henry Mundt, Jr., all of Chicago.





Scientific Exhibits

It was generally believed that the scientific exhibits of the 1947 meeting could not be topped. Those of 1948 performed the feat. Assembled under the direction of John A. Mart, Chicago, they were displayed perfectly. Above. Bernard Chapman explains "Cancer Diagnosis in a Small Community Hospital," the exhibit he and Isadore Pilot of Edgewater Hospital, Chicago, assembled. It won a Bronze Medal for education value. Right. John W. Huffman of Northwestern University Medical School stands by one of the complex models he constructed for his exhibit "A New Concept of the Paraurethral Glands." He won a Silver Medal for original work.



Below. Fenton Schaffner explains "Radioactive Isotopes." Co-exhibitors were M. T. Friedell and William Pickett. They were awarded a Bronze Medal for original work.



Above. Louis Krasno and Mary Karp view their exhibit, "Inhalation of Penicillin Dust." Paul S. Rhoads was associated with them in its preparation. They won a Bronze Medal for original work.







Many of the exhibits went on to further fame at the A.M.A. Convention on Navy Pier, Chicago. John A. Mart hopes that the manner of showing the work will attract as many valuable exhibits at the next meeting.

Right. James M. Fritz (at right) points out features of the dispiay he and W. E. Adams of the University of Chicago created. They were awarded a Bronze Medai for educationai vaiue.

The Technical Exhibits

Beiow. A. H. Phiiips, Chicago, studies the sampie and gets a sales talk from Mr. J. Leo McMahon of the Smith-Dorsey Company. There were many "first-time" exhibitors at this meeting.



Beiow. H. J. Rothenberg, Chicago, considers the merit of a product offered by the Ciba representative. Exhibitors were pleased with the interest shown by attending doctors.



CASE REPORTS



Subacute Bacterial Endocarditis Treated With Streptomycin

Julius N. Bell, M.D.
Kewanee

This is a report of a case of subacute bacterial endocarditis which responded to therapy with streptomycin after failure to respond to penicillin therapy.

The patient is a thirty-one (31) year old colored female who presented herself on February 13, 1946 with complaints of a poly-arthritis of two and one-half (2½) years duration. The pains were aching, intermittent, and involved the right hip, left shoulder, left knee, left wrist, right shoulder, in that order. The pain was relieved by heat. Her present episode began on January 5, 1946 with pain in the left knee and had continued. General and negative revealed a weight loss of fifty-five pounds in six (6) months on a self imposed diet. Venereal disease was denied. Past history revealed a pneumonia in 1943.

Examination revealed a well developed, well nourished, colored female, not acutely ill. Blood pressure 120/80, temperature 98°, pulse 80, respiration 16. Head and neck were negative. Examination of the chest revealed a late diastolic and soft systolic murmur at the apex. A^2 was equal to P^2. Lungs were clear and resonant. Abdomen and back were negative. Pelvic examination revealed a uterus enlarged 100% (fibroid) and a cervical erosion. Rectal was negative. The extremities showed fusiform swelling of the proximal interphalangeal joints. There was pain on flexion of the left knee.

Laboratory work revealed: Serology negative: hemoglobin 76%: red blood count-4,500,000: white blood count-5,800: urine-negative: electrocardiograph-normal tracing: two meter chest x-ray revealed hypertrophied inflow tract, otherwise negative: sedimentation time was twenty-five (25) mm. in sixty (60) minutes.

Impression was (1) rheumatoid arthritis, (2) rheumatic heart disease with mitral stenosis and

insuffiency, class 1, (3) small fibroid uterus.

One month later, the patient began to exhibit weakness, malaise, and fever up to 103°, spiking in type. Examination revealed a blowing systolic murmur in place of the previous soft murmur at the apex. There were no other changes. A diagnosis of subacute bacterial endocarditis was made and a culture drawn on March 12, 1946 revealed streptococcus viridans; all other cultures (twenty-three in all) drawn since were negative. The patient continued a rapid down hill course, with septic temperature and chills, and despite the lack of a corroborating culture, penicillin 800,000 units I.V. was initiated on April 30, 1946. There was no evident improvement, and three weeks later (May 21, 1946) the patient began to decompensate, voided a bloody urine, and temperatures rose to 105°F. No petechiae were noted. The intravenous route was discontinued, and penicillin was given every three (3) hours intramuscularly to a total of 800,000 units daily.

During this time, despite repeated transfusions, her red blood count dropped from 4,500-000 to 2,600,000; hemoglobin dropped from 75% to 39%; sedimentation time increased to fifty (50) mm. in twenty (20) minutes (normal equals 4-5mm. in sixty (60) minutes).

Since the patient was slipping fast, an attempt was made to start therapy with streptomycin, which was yet under control of the National Research Council, and Dr. Chester S. Keefer supplied twenty (20) gms. of the material. Streptomycin was started June 4, 1946 I.M., on the eighty-fourth day of the disease, 0.5 gm. every six (6) hours (two (2) gms. daily) for ten days. Under this therapy, the sedimentation time dropped to fifty (50) mm. in sixty minutes (as compared to previous rate of fifty (50) mm. in twenty minutes). The temperature curve dropped to 98° for the first time since the onset of the disease. Three weeks after streptomycin therapy, temperature was normal and has remained normal since. The blowing murmur at the apex became soft, and the patient was able to sit up in bed. General improvement, increased appetite, and weight gain soon became evident. Other than for the rheumatoid arthritis, the patient has remained well since, one and one half years after the onset of the disease.

"MY PATIENT"

One of the most frequent remarks one hears in the shop talk of doctors is "my patient." They talk in the most possessive manner. Too often they regard the patient as personal property. Some doctors actually become perturbed when they see a previous patient admitted to a hospital on another doctor's service. They go so far as to remark that doctor so-and-so "stole" their patient.

The patient chooses the doctor. The doctor does not choose the patient. Don't flatter yourself because a patient consults you in your office or calls you to his home. Don't become too possessive. Remember that the patient is here just so long as you render him service that is satisfactory to him at a price he is willing to pay. You must play fair with that patient.

A busy doctor may send a young doctor to call on one of his patients. The patient may be pleased with that service and call that doctor when he desires his services. The patient has every right to do this, and the young doctor has every right to render this service.

In order to maintain the patient as "your patient," it is necessary for you to render satisfactory service.—*Pennsylvania Medical Journal,* October, 1947.

HOUSE OF DELEGATES



SECOND SESSION, MAY 12, 1948

The second session of House of Delegates was called to order by the President, Dr. Irving H. Neece, on Wednesday, May 12, 1948, at 9:40 A.M.

THE PRESIDENT: We have with us a very distinguished guest, the President-Elect of the American Medical Association, Dr. R. L. Sensenich. I am going to ask him to speak at this time.

DR. R. L. SENSENICH: I am quite overcome. As an old neighbor and friend in close touch with your Society for years, it is very courteous of you to be so nice. I am going to take only a few minutes.

There are a couple of things I should like to say. One is, first of all, as far as compulsory sickness insurance is concerned, that is a dead issue for the moment. That does not mean that we do not need to keep in touch with it, but there is less interest in it than there has been for years.

Secondly, there is something before Congress at the present time in which we are properly interested — that is the compulsory draft of physicians up to age 45. Your state society, as all other state societies, was informed by telegram some time ago when this action was first proposed. Our Council on Emergency Medical Service has been working on it.

I think at the moment there is nothing else immediately impending in a legislative way. As I said briefly last night before dinner, at no time have I ever known the medical profession to be in such a strong position in which they have been consulted more often and their wishes observed. We must look after ourselves as far as the military organization is concerned; things have moved fast in our war preparations program and in the main it has been quite acceptable.

If the medical profession is properly insistent that it get further representation, it might step it up to where it has direct access to military authority. If the profession stands strong enough it can have it. Thus far nothing has been done in the new plan, but it has been recommended. A little pressure on that might help. I am sure the House of Delegates of the American Medical Association will take action.

I have been very happy to have been here.

THE PRESIDENT: I want to thank you Dr. Sensenich for this fine presentation this morning. It is something we all wanted to hear.

The next order of business will be the report of the Credentials Committee.

DR. E. S. HAMILTON, Kankakee: There were present at this meeting and today 163 delegates and officers. Of the 163, 45 delegates are present this morning from the Chicago Medical Society, 60 from down state, and 16 members of the Council and officers of the Society, making a total of 121 men who have signed attendance slips and are eligible to participate in the deliberations of the House. I move you, Mr. President, that this constitute the voting strength of the House, 121. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary.

DR. C. H. PHIFER, Chicago: I move that the attendance slips constitute the official roll call. (Motion seconded by Dr. G. Henry Mundt, Chicago, and carried.

THE PRESIDENT: The next order of business is the reading of the minutes of the last meeting of the House.

DR. W. E. KITTLER, Rochelle: I move that the reading of the minutes be dispensed with. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

THE PRESIDENT: The next order of business is the election of officers. Nominations for president-elect are called for.

DR. G. C. OTRICH, Belleville: It gives me a great deal of pleasure to present the name which I am going to offer for the office of President-elect of this organization. This man has had all the experience practically there is to be had; he has been working for years and years for the benefit of our organization and of organized medicine; he has been secretary of his own society; he has been in the House of Delegates, in the Council, and has served as Chairman of the Council. I feel he will make a very representative man to take the helm at the proper time. With that introduction I want to present the name of Dr. Walter D. Stevenson of Quincy. (Motion seconded by Dr. W. O. Thompson and many).

DR. W. W. FULLERTON, Steeleville: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Stevenson. (Motion seconded by Dr. L. J. Hughes, Elgin, and carried).

(The ballot was cast and the President declared Dr. Stevenson elected).

THE PRESIDENT: Nominations are in order for First Vice-President.

DR. H. K. SCATLIFF, Chicago: Knowing the amount of work required to put on a meeting of the kind we have had this week, and how much was done by the Chairman, I wish to nominate Dr. R. C. Oldfield, Oak Park, for First Vice-President. (Seconded by Dr. Fred H. Muller, Chicago).

DR. WADE HARKER, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Oldfield. (Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

(The ballot was cast and the President declared Dr. R. C. Oldfield elected as First Vice-President).

THE PRESIDENT: Nominations are in order for Second Vice-President.

DR. OSCAR HAWKINSON, Chicago: We need a good strong man to help the First Vice-President, and we have that man right here in Chicago, Dr. Fred H. Muller. (Nomination seconded by Dr. J. J. Moore, Chicago, and Dr. W. E. Kittler, Rochelle).

DR. J. J. MOORE, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Muller. (Seconded by Dr. W. O. Thompson, Chicago, and carried).

(The ballot was cast and the President declared Dr. Fred H. Muller elected as second Vice-President).

The PRESIDENT: Nominations are in order for Secretary-Treasurer.

DR. LEE O. FRECH, Decatur: As long as we need a very, very strong man for secretary-treasurer, and as long as we have that gentleman, I would like to place in nomination Dr. Harold M. Camp, Monmouth, to succeed himself. (Seconded by Dr. Harry Olin, Chicago, and many others).

DR. FRED H. MULLER, Chicago: I move the nominations be closed and the President cast the affirmative ballot for Dr. Camp. Seconded by Dr. Oscar Hawkinson, Chicago, and carried).

(The ballot was cast and the President declared Dr. Harold M. Camp elected as Secretary-Treasurer).

DR. MATHER PFEIFFENBERGER, Alton: I would like to call the attention of the House to the fact that this worthy Secretary has given 24 years as secretary. I think some acknowledgement should be made.

THE PRESIDENT: The next order of business is the election of Councilors; nominations are in order for Councilor of the Second District to fill the unexpired term of two years of Dr. H. L. Pettit, deceased.

DR. J. H. EDGCOMB, Ottawa: I would like to place in nomination the name of Dr. J. T. O'Neill, Ottawa. (Seconded by W. E. Kittler, Rochelle).

DR. L. J. HUGHES, Elgin: I move that the nominations be closed and Secretary cast the affirmative ballot for Dr. O'Neill. (Motion seconded by Dr. J. H. Edgcomb, Ottawa, and carried).

(The ballot was cast and the President declared Dr. J. T. O'Neill, Ottawa, elected as councilor of the Second District).

THE PRESIDENT: Nominations are in order to fill the unexpired term of two years of Dr. D. B. Pond, resigned as Councilor of the Third District.

DR. C. H. PHIFER, Chicago: I would like to place in nomination Dr. F. Lee Stone of Chicago. (Seconded by Dr. Oscar Hawkinson, Chicago).

DR. HAROLD W. MILLER, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Stone. (Motion seconded by Dr. Charles Roth, Chicago, and carried).

(The ballot was cast and the President declared Dr. F. Lee Stone elected as Councilor of the Third District.)

THE PRESIDENT: There are two other Councilors to be elected from the Third District, Dr. Oscar Hawkinson and Dr. Leo P. A. Sweeney retiring.

DR. P. E. HOPKINS, Chicago: It gives me pleasure to place in nomination Dr. Oscar Hawkinson, Chicago, to succeed himself. (Seconded by Dr. Robert H. Hayes, Chicago).

DR. W. O. THOMPSON, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr.

Hawkinson. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

(The ballot was cast and the President declared Dr. Oscar Hawkinson reelected as Councilor of the Third District).

THE PRESIDENT: Nominations are in order for Councilor of the Third District to succeed Dr. Leo P. A. Sweeney.

DR. G. H. MUNDT, Chicago: If there is any man in the Chicago delegation who is not very sorry to see Leo Sweeney resign I do not know him. You will pardon me, Mr. President, for making that remark. If we are going to present a man for this job, then I present Dr. A. M. Vaughn. (Seconded by Dr. F. P. Hammond, Chicago).

DR. J. J. MOORE, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Vaughn. (Motion seconded by W. O. Thompson, Chicago, and carried).

(The ballot was cast and the President declared Dr. A. M. Vaughn elected as Councilor of the Third District).

THE PRESIDENT: I am sure the remarks Dr. Mundt just made carry throughout the Council.

Nominations are in order for Councilor of the Sixth District to replace Dr. Walter D. Stevenson, Quincy.

DR. W. H. NEWCOMB, Jacksonville: I wish to place in nomination Dr. F. Garm Norbury of Jacksonville. (Seconded by Dr. L. J. Hughes, Elgin).

DR. HAROLD SWANBERG, Quincy: I move the nominations be closed and the Secretary cast the affirmative ballot for Dr. Norbury. (Motion seconded by Dr. G. C. Otrich, Belleville, and carried).

(The ballot was cast and the President declared Dr. F. Garm Norbury elected Councilor of the Sixth District).

THE PRESIDENT: Nominations are in order for Councilor of the Ninth District, Dr. Charles O. Lane, West Frankfort, retiring.

DR. B. E. MONTGOMERY, Harrisburg: I wish to place in nomination Dr. C. O. Lane to succeed himself. (Seconded by Dr. H. A. Felts, Marion).

DR. R. K. PACKARD, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Lane. (Motion seconded by G. C. Otrich, Belleville, and carried).

(The ballot was cast and the President declared Dr. C. O. Lane reelected as Councilor of the Ninth District).

THE PRESIDENT: Nominations are in order for Councilor of the Tenth District, Dr. G. C. Otrich, Belleville, retiring.

DR. F. E. BHISS, East St. Louis: I wish to nominate Dr. G. C. Otrich to succeed himself. (Seconded by Dr. Mather Pfeiffenberger, Alton).

DR. W. W. FULLERTON, Steeleville: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Otrich. (Motion seconded by Dr. L. J. Hughes, Chicago, and carried).

(The ballot was cast and the President declared Dr. G. C. Otrich reelected as Councilor of the Tenth District).

THE PRESIDENT: Nominations are in order for election of delegates to the American Medical Association from Cook County, Drs. Rollo K. Packard, Charles H. Phifer, G. Henry Mundt, retiring.

(The following delegates were nominated, the ballot was cast and the President declared them elected: Drs. Rollo K. Packard, Chicago, Charles H. Phifer, Chicago, and G. Henry Mundt, Chicago).

THE PRESIDENT: Two delegates to the American Medical Association from downstate are retiring, Drs. Edwin S. Hamilton, Kankakee, and Willis I. Lewis, Herrin.

(Drs. Edwin S. Hamilton and Willis I. Lewis were nominated to succeed themselves, the ballot cast and the President declared them elected).

THE PRESIDENT: Nominations are in order for election of alternate delegates to the American Medical Association, Drs. Frank L. Brown, Chicago, Darwin B. Pond, Chicago, Gustav Kaufman, Chicago, Bernard Klein, Joliet, and K. B. Rieger, Freeport, retiring.

(The following alternate delegates were nominated, the ballot was cast and the President declared them elected: Drs. Frank L. Brown, Karl Vehe, and Gustav Kaufman from Cook County, and Bernard Klein, Joliet, and K. B. Rieger, Freeport, from downstate).

THE PRESIDENT: The next order of business is the election of Standing Committees. The first is the Medico-Legal Committee, two to be elected each year for a term of three years, Drs. Oscar Hawkinson, Chicago, and A. L. Nickerson, Kankakee, retiring.

(The following members were nominated, the ballot was cast and the President declared them elected: Drs. Oscar Hawkinson, Chicago, and A. L. Nickerson, Kankakee.

THE PRESIDENT: The next Committee is that on Medical Education and Hospitals, one to be elected each year for a term of three years, Dr. Willard O. Thompson, Chicago, the Chairman, retiring.

DR. KARL VEHE, Chicago: I would like to place in nomination Dr. Willard O. Thompson, Chicago, to succeed himself. (Motion seconded by Dr. E. S. Hamilton, and carried).

(The ballot was cast and the President declared Dr. Willard O. Thompson elected for a term of three years).

THE PRESIDENT: The Committee on Medical Benevolence, one to be elected each year for a term of three years, Dr. Oscar Hawkinson, Chicago, retiring.

DR. F. P. HAMMOND, Chicago: I wish to place in nomination Dr. Oscar Hawkinson, Chicago, to succeed himself. (Motion seconded by Dr. P. E. Hopkins, Chicago).

(The ballot was cast and the President declared Dr. Oscar Hawkinson, elected).

THE PRESIDENT: The Committee on Medical Testimony, the first election under the new by-laws,

Drs. Oscar Hawkinson, Oak Park, Chairman, for 4 year term, E. P. Coleman, Canton, for a 4 year term, Warren W. Furey, Chicago, for a 3 year term, W. J. Gillesby, Effingham, for a 3 year term, Walter L. Palmer, Chicago, for a 2 year term, Arthur F. Goodyear, Decatur, for a 2 year term, and Harry A. Oberhelman, Chicago, and E. H. Weld, Rockford, for a 1 year term.

THE SECRETARY: I would like to give an explanation. Last year this House of Delegates revised the by-laws, constituting this Committee. This was done after the elections were all over. At the moment we lost sight of the fact that it was necessary to have a Committee for the current year, consequently it was up to the President to name a Committee until this meeting of the House of Delegates. This arrangement is in accordance with the by-laws you passed last year. There will be two men for four years, two for three years, two for two years, and two for one year, and thereafter their successors are to be elected for a four year term.

DR. FRANK DENEEN, Bloomington: I move that this plan be adopted and the slate named elected as indicated. (Motion seconded by Dr. W. O. Thompson, Chicago, and carried).

(The ballot was cast and the President declared these gentlemen elected for the terms indicated above).

THE PRESIDENT: Committee on Archives, Ellsworth Black, Jacksonville, Secretary, resigned.

DR. R. H. HAYES, Chicago: I would like to place in nomination the name of a man who is interested in the welfare of medicine, Dr. J. J. Moore, Chicago. (Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

DR. W. O. THOMPSON, Chicago: I move the nominations be closed and the Secretary cast the affirmative ballot for Dr. Moore. (Motion seconded by Dr. G. Henry Mundt, Chicago, and carried).

(The ballot was cast and the President declared Dr. J. J. Moore elected as a member of the Committee on Archives).

THE PRESIDENT: The next order of business is the selection of a meeting place for the 1949 annual meeting.

DR. G. C. OTRICH, Belleville: I move this matter be referred to the Council with power to act. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

THE PRESIDENT: The next order of business is the report of Reference Committees and action on same. The first report will be from the Committee on Reports of Officers.

DR. CHARLES H. PHIFER, Chicago: The Committee wishes to present the following report:

On Report of the President: We have read with great interest the report of the President, and wish to commend him for his outstanding leadership during the past year. We deeply appreciate the many problems and demands on the time and energies of a President of a great medical society during this troublesome era. In view of the nationwide agitation for improvement of rural medical service, it is most comforting to your Reference Committee to learn that there is evidence of normal medical service being established throughout the state.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. Oscar Hawkinson, Oak Park, and carried).

The President has called our attention to the urgent need for an Assistant to Dr. Camp. This is all the more necessary when we think of the many duties required of his office and of the necessity of having someone properly trained and educated in the devious and ever-increasing obligations of the Secretary's office. A qualified physician is not easily obtained. It will require time and effort. Your Reference Committee urges the House of Delegates to empower the Council to investigate and employ a capable Assistant to Dr. Camp.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

The President calls your attention to the cooperation of the Department of Public Health in this State. Your Reference Committee greatly appreciates the fine spirit of cooperation that is manifested between the Director of the Department of Public Health and the State Society. There is, however, in the opinion of this Committee, one phase of the activities that is sometimes misleading. In local news releases Public Health officers, nurses, and other case workers often claim credit for philanthropic deeds performed by local medical societies as a group and individually. The implication behind this type of publicity is that these achievements were not done before the creation of the local county health units. Your Committee deplores this practice and recommends that the House of Delegates instruct the Council to admonish the Director of Public Health in the State of Illinois in regard to this type of publicity and to try to correct these erroneous impressions.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. R. K. Packard, Chicago, and carried).

In commenting upon the President's recommendations in regard to medical education, we concur most heartily in his five general principles. In connection with the President's recommendations on medical education, your Reference Committee believes that a carefully controlled Preceptor System would show the benefits of general practice and the advantages of smaller urban centers from the social as well as the financial aspect. Summer vacations between the second and third years and the third and fourth years spent with a carefully selected preceptor would be mutually helpful to the student and the preceptor. Your Reference Committee recommends that the House of Delegates instruct its Secretary to forward this recommendation to the Deans of the Medical Schools in the State of Illinois for their consideration as a part of their medical curriculum.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

In reference to medical men speaking to lay meetings, we believe that medical men should realize their own potentialities and shortcomings. A poor speaker does more harm than no speaker, and a talk poorly planned and poorly executed had better be left unsaid.

The preceding paragraph applies to the Educational Committee. A struggling Society addressed by a poor speaker requires about two to three months of excellent speakers to recover from the shock.

It has been brought to the attention of this Reference Committee the great delay in certifying delegates. The opinion of your Reference Committee is that your President and Officers should give careful consideration to the streamlining and speeding up of the certification of delegates.

(DR. PHIFER: I move the adoption of the Reference Committee's report on the Report of the President, as a whole. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

On Report of the President-Elect: Your Reference Committee notes the very modest statement of your President-Elect. We are very keenly aware of his long and valuable experience as a member of the Council, and of his intimate knowledge of its problems. We likewise appreciate the great amount of time, energy, and travel during his tenure as President-Elect in carrying the information of the Society's activities to all Sections of the state. We commend his report.

(DR. PHIFER: I move the approval of this report. Motion seconded by Dr. Harry Olin, Chicago, and carried).

On Report of the Secretary-Treasurer: This report covers many details and emphasizes the multitudinous duties and activities of a secretary of a large and active state medical society of today. Included in this report are the constructive efforts of your Secretary to assist in the locating of physicians in rural areas. This activity is to be heartily commended and encouraged. In this connection, we note the eccentric demands in certain communities which is merely another evidence of the odd psychology existing during the present social upheaval.

In connection with the Secretary's report on the "Committee on Military Affairs and Emergency Medical Service", we note the recent news release that the Armed Forces are going to ask for one physician for each 200 members in the Armed Forces. This, in the opinion of your Reference Committee, is an exorbitant demand. We believe that your Committee on Military Affairs and Emergency Medical Service should protest this ratio through the Council on National Emergency Medical Service of the A.M.A.

(DR. PHIFER: I move the adoption of that portion of the report. Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

The continuing success of the Post-Graduate Education Conference is to be highly commended.

This Reference Committee notes with pride the excellent financial status of our Society.

We recommend the adoption of the Secretary-Treasurer's report.

(DR. PHIFER: I move the adoption of the Secretary-Treasurer's report. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

On the Report of the Chairman of the Council: We have carefully reviewed his elaborate report regarding the many activities of the Council during the present year. Each requires investigation and careful evaluation. These are direct evidences of the many social and economic problems that have confronted the medical society for the past fifteen years. Many of them are most exhausting and time-consuming in their demands.

We note the Council's effort to clarify the functions of its different committees, to strengthen their activities and avoid overlapping.

The work of the Committee on Rural Health is to be particularly commended.

We note with pleasure the institution of round-up meetings of county society officers during the past year to acquaint them with state society activities and of their obligations as officers in their own communities.

This Reference Committee believes that the values of this program could be enhanced by presenting it on a sectional basis.

We recommend the adoption of this report.

(DR. PHIFER: I move the adoption of the Reference Committee's report on the report of the Chairman of the Council. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

Respectfully submitted,
W. J. GILLESBY,
ALBERT NEHF,
FRED H. MULLER,
CHARLES H. PHIFER, Chairman

(DR. PHIFER: I move the adoption of the report as a whole. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

THE PRESIDENT: I want to thank the Committee for this very excellent report.

COMMITTEE ON REPORTS OF COUNCILORS
Presented by Dr. Lee O. Frech

Report of Councilor of First District: Your Committee wishes to commend this Councilor for his activities and faithful attention to his Councilor duties.

Report of Councilor of Second District: The second district was well taken care of by its Councilor who was active in his Councilor duties.

We note with regret the recent passing of Councilor H. L. Pettitt of the second district, and feel that his district as well as the Council has sustained a great loss.

Report of Councilors of Third District: We commend the Councilors of the Third District for the brevity of their report in comparison with the enormous amount of work done. We congratulate the district on the establishment of the Post-Graduate courses as well as the annual Chicago Medical Clinical Conference. We wish to call attention to the members of this House of Delegates as well as to the entire membership of this medical society, the establishment of "The Week in Chicago Medicine", the perusal of which will enable a visiting physician to acquaint himself with all of the medical activities in Chicago for any given day or week.

Report of Councilor of Fourth District: We note that the component societies in this district have been more active this year, and we suspect your Councilor here had something to do with this increased activity.

Report of Councilor of Fifth District: We commend the Councilor of the Fifth District for his faithful interest in, and his attention to, the welfare of his district.

Report of Councilor of Sixth District: Your Committee notes the excellent condition of the district for which the Councilor of this district is undoubtedly, to a considerable degree, responsible. We commend the Councilor for his attention to the district while carrying on the arduous duties as Chairman of the Council.

Report of Councilor of Seventh District: The Councilor of this district, we note, has been active and as a result his district appears in good condition.

Report of Councilor of Eighth District: We note the activity of the Councilor of this district and wish to commend him for his enthusiastic attention to Councilor duties.

Report of Councilor of Ninth District: Your Committee realizes that the Councilor of this district has a hard job from the organizational standpoint because of wide area and the small membership of his county societies. We feel that he has done a good job, and we are of the opinion that this big problem can be helped materially possibly by more combined meetings in his district.

Report of Councilor of Tenth District: We feel that the Councilor of District 10 is wide awake as to what has, is being, and should be done to promote the welfare of his constituents.

Report of Councilor of Eleventh District: The Councilor of District 11 is always on the job and considering his numerous and wide variety of activities, we wonder how he is able to do all that he does. His report indicates that he is in close touch with his component county medical societies.

Report of Councilors-at-large: The Councilors-at-large are to be commended for their interest in the various phases of medical organizational activities and for their activities in promoting the welfare of the state and county medical societies.

It has been, and is now, most desirable that the State Medical Society be in close touch and on an agreeable working basis with both the state government and the State Department of Public Health.

Conclusion: It is the sentiment of your Committee that Councilor reports in general should explain more in detail concerning the active thoughts, needs and wants of the members of local medical societies. Expressions of opinions on all subjects (medical) should enhance the value of Councilor reports and would aid the State Medical Society in functioning better toward the personal, medical welfare of its members. Some phases of future activity, needs of county medical societies, should be incorporated in Councilor reports for the benefit of discussion and future adoption if found feasible.

Respectfully submitted,

W. H. NEWCOMB
G. HENRY MUNDT
A. M. VAUGHN
L. O. FRECH, Chairman

DR. FRECH: I move you the adoption of this report as a whole. (Motion seconded by Dr. W. O. Thompson, Chicago, and carried).

Report of The Reference Committee to Receive and Report on Reports of Standing Committees

(Presented by Dr. J. P. Simmonds)

To the House of Delegates, Illinois State Medical Society:

It is obviously unnecessary for a reference committee to summarize reports of which all members of the House of Delegates have complete copies. We shall, therefore, limit consideration of the reports of the six committees referred to this committee to pertinent comments upon their contents and to presenting the opinion of this reference committee upon the several recommendations offered by the original committees.

The Report of the *Committee on Medical Service and Public Relations* is comprehensive and contains the results of much conscientious work on the part of its members. The Illinois Medical Society has shown much progress during the past year in the fields of Medical Service and Public Relations. It is evident that the general public, under the guidance of this Committee, is learning many new facts concerning the motives, the objectives and the activities in the public interest of the medical profession. This is mutually advantageous to both the public and the profession.

The committee on Medical Service and Public Relations makes certain recommendations which this reference committee has summarized and presents to the House of Delegates for their approval:

1. That the public relations effort be extended to the counties and that this effort be coordinated throughout the State of Illinois by freer consultation on problems of public relations by chairmen and officers of county societies with this Committee and the public relations counsel of the State Society;

2. That the organized medical profession assume an aggresive and continuous leadership in all matters pertaining to health in order that the public may know that the medical profession is actually the moving force behind all advances in public health. This leadership should begin at the county level. The Committee on Medical Service and Public Relations suggests three steps by which this leadership may be made effective:

(a) The first step is the organization of a health council in each community, as recommended by the American Medical Association. The local physicians should take the lead in the formation of such health councils and an active part in the organization, planning and execution of the activities of such councils and should see that the community is kept informed of the facts.

(b) The second step should be a survey of the community to determine its health needs. This survey would form the basis of comprehensive planning for improvement of health conditions in the community.

(c) The third step involves the formulation of methods by which the health needs of the community may be met. The community health council can, through its individual and combined influence, do much to meet the unmet needs of the community.

Your reference committee recommends:

1. That the House of Delegates approve the above recommendations of the Committee on Medical Service and Public Relations:

2. That each member of the House of Delegates urge the officers and committees of his county medical society to make every effort to carry out these recommendations; and

3. That the Secretary of the Illinois State Medical Society be instructed to send a copy of these recommendations to the Secretary of each county medical society in this State with the recommendation that they be put into effect in their respective communities.

The Committee on Medical Service and Public Relations asks approval by the House of Delegates for the following 1949 Legislative Program of the Chicago-Cook County Committee for the Eradication of Tuberculosis:

1. A raise in the peg levy for the (Chicago) Municipal Tuberculosis Sanitarium to $6,000,000;

2. Provision for three additional 250 bed tuberculosis hospitals—two to be located in Chicago and one downstate;

3. An appropriation of $3,000,000 to the State Department of Public Health, the money to be used to assist local sanitarium boards whose tax funds are insufficient to carry out their tuberculosis programs;

4. To transfer to the State Department of Public Health the $875,000 allotted in 1947 for a tuberculosis sanitarium in Savanna, Illinois. The sanitarium has not been built and the money will automatically be returned to the State. The State Department of Public Health would use this money to assist local sanitaria to enlarge or modernize existing facilities, with the understanding that the local sanitaria would accept patients from adjoining counties whenever beds were available.

5. The formulation of an agreement wherby the State Department of Public Health can lease or in some other manner surrender the management of state-built sanitaria to local groups.

(DR. SIMONDS: I move the adoption of this section of the report and approval of the recommendations. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

The *Legislative Report* presented by Mr. John W. Neal is commended for its brevity and for the forcefulness with which it brings to the attention of the medical profession the dangers that beset the practice of the best type of medicine and the public health by ill-advised legislation and by the propaganda of groups with special interests that are not always in harmony with the good of the community.

The Report of the *Committee on Medical Education and Hospitals* is commended for its comprehensiveness and for the clearness with which it presents the problems pertaining to this field. Your reference committee recommends the approval of the following recommendations of the above Committee:

1. That hospitals be urged to make every effort to provide teaching programs for internes and residents that are sufficiently attractive and to raise their standards sufficiently high that full approval may be obtained. One method of accomplishing this end is suggested in the report of the Committee.

2. That hospitals be urged to set up Departments of General Practice with representation on the Executive Committee of the Staff for "general physicians". In order that this plan may not be unfair to specialists who have spent many years in preparation for the practice of their specialities, places on hospital staffs might be limited to those "general physicians" who have shown themselves to be progressive by attendance on postgraduate courses offered in the various medical centers.

3. That hospital authorities be urged to consider more carefully the economic status of nurses in order that the present shortage of nurses may be alleviated. It is the opinion of the Committee on Medical Education and Hospitals that the most important cause of the shortage of nurses is economic.

4. That, in order to aid "general physicians" to advance themselves, the Committee on Postgraduate Medical Education of the Illinois State Medical Society expand its present plan of conducting postgraduate days in various parts of the State.

The Committee on Medical Education and Hospitals is to be commended for its efforts to assist the Chicago Medical School, the only unapproved medical school in the United States, to secure sufficient clinical facilities to warrant its approval.

(DR. SIMONDS: I move the adoption of this portion of the report and the approval of the recommendations. Motion seconded by Dr. E. E. Davis, Avon, and carried).

The Report of the *Committee on Medical Benevolence* is brief but presents effectively the problems met by that Committee. Since resolutions pertaining to the work of this Committee are to be presented and considered by the House of Delegates under the proper order of business, your reference committee makes no specific recommendations concerning this report. It respectfully suggests, however, that, if no agreement is had on these resolutions, a solution of the problem might be reached if, for the present, the name of the Committee be retained and the fund be kept small until the report of the special committee authorized last year by the House of Delegates has been presented for consideration.

The Report of the *Medicolegal Committee* contains one recommendation which your reference committee requests the House of Delegates to approve; namely, that the attention of the members of the Illinois State Medical Society be called to the increasing number of

malpractice suits being filed in the courts and that members of the Society be urged to secure adequate medicolegal protection.

(DR. SIMONDS: I move the adoption of this portion of the report and the approval of the recommendation. Motion seconded by Dr. E. E. Davis, Avon, and carried).

The *Committee on Medical Testimony* is commended for having performed its important but unpleasant task diplomatically and well. This Committee states that it has the active cooperation of the Bar Association in attempts to discourage medical testimony which is confusing, contradictory or willfully misleading. It is understandable that a physician in the unnatural environment of the witness stand and because of his lack of familiarity with court procedure and the strange rules of legal evidence, may unintentionally render testimony that is confusing or contradictory. But a physician can only render willfully misleading testimony with the connivance of the lawyer in the case. Perhaps this Committee in its next Report will inform the House of Delegates to what extent the Bar Association is actively discouraging the connivance of lawyers in the presentation of evidence of this kind.

The *Committee on Archives* is commended for its cooperative effort with the Committee on Medical History to plan another volume carrying forward the "History of the Illinois State Medical Society, and the Progress of Medicine in Illinois.

(DR. SIMONDS: I move the adoption of this portion of the report. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

Respectfully submitted,
KARL VEHE
GEORGE E. KIRBY
JAMES P. SIMONDS, Chairman

(DR. SIMONDS: I move the adoption of the report as a whole. Motion seconded by Dr. O. W. Rest, Chicago, and carried).

REPORTS OF COUNCIL COMMITTEES — COMMITTEE "A"
(Presented by Dr. Frank M. Hagans)

To the Members of the House of Delegates:

It is my pleasure and privilege to present herewith, under the title Committee "A" the Reference Committee's report on reports of Council Committees to receive and report on Reports of the following:

1. *Educational Committee*: The members of this Committee receive the sanction of our Committee wholeheartedly, and we approve the manner in which this work was conducted the past year relative to the Speakers' Bureau, Health Talks, exhibits, package libraries, literature and queries concerning services, and also including the news pages of the Journal supplied by the Secretary.

(DR. HAGANS: I move the adoption of this portion of the report. Motion seconded by Dr. Harry Olin, Chicago, and carried).

2. *Scientific Service Committee*: Your Committee approves the manner in which this work has been conducted the past year and thinks the per diem of ten dollars allowed for speakers, should be continued. It is gratifying to note the increase in number of speakers added to the list the past year.

(DR. HAGANS: I move the adoption of this portion of the report. Motion seconded by Dr. Harry Olin, Chicago, and carried).

3. *Post-Graduate Committee*: The work of this Committee is especially gratifying. The twelve postgraduate meetings held the past year throughout various areas of the state were well attended. Favorable comments from all over the state indicate the popularity of postgraduate meetings.

(DR. HAGANS: I move the adoption of this portion of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

4. *Fifty Year Club Committee*: This important Committee under the able chairmanship of Andy Hall has done a good job, and we are pleased to note a total membership of 550 members. As a committee we certainly recommend the continuance of the annual banquet or any additional complimentary gesture the Committee wishes to consider.

(DR. HAGANS: I move the adoption of this portion of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

5. *Medical Economics Committee*: The publication of monthly articles and the plan instituted to develop a backlog of material, evidently has proven successful. We trust the idea will act as an incentive for more contributions by more able men.

It is our desire to compliment the members of this Committee on their progressiveness and preparation of essential editorials and endorse the continuance of such a program.

(DR. HAGANS: I move the adoption of this portion of the report. Motion seconded by Dr. Harry Olin, Chicago, and carried).

Respectfully submitted,
M. M. HOELTGEN
J. J. MOORE
L. S. REAVLEY
F. M. HAGANS, Chairman

(DR. HAGANS: I move the adoption of the report as a whole. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

REPORTS OF COUNCIL COMMITTEES — COMMITTEE "B"
(Presented by Dr. Richard Greening)

DR. GREENING: This report is on four committees. We will not report on them individually. These reports were considered at length.

1. *Advisory Committee to the Illinois Public Aid Commission*: Approval of report as printed with a word of commendation for the fine job done.

2. *Constitution and By-Laws Committee*: Approval of report as printed with comment on item 3. This committee to abide by the decision of the Resolutions Committee covering this item as presented to the House of Delegates, Monday, May 10.

3. *Advisory Committee, Child Health Survey, American Academy of Pediatrics.* Report is incomplete. No comment.

4. *Committee on Voluntary Prepayment Plans for*

Medical and Surgical Care: A tremendous amount of work has been done by this committee. They have made a thorough study of this very perplexing problem and have condensed this program into as concise a form as it was possible to do.

Respectfully submitted,
RICHARD GREENING, Chairman
JAMES H. HUTTON
H. A. FELTS
FRANK DENEEN

DR. GREENING: I move the adoption of this report. (Motion seconded by Dr. Frank M. Deneen).

DR. R. K. PACKARD, Chicago: I would like to discuss one portion of this report.

DR. FRED H. MULLER, Chicago: I move you that we go into executive session. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

THE PRESIDENT: I shall appoint as Sergeant-at-arms Drs. Wade Harker and Everett P. Coleman.

DR. J. J. MOORE, Chicago: I move you that Mrs. Fraser, Miss Frances Zimmer, Mr. Neal, Mr. Leary and Miss Margaret Maloney be permitted to remain. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

DR. W. E. KITTLER, Rochelle: I would like to make a motion that secretaries of county societies be allowed to remain because they have their finger on the pulse. (Motion seconded by Dr. W. O. Thompson, Chicago).

DR. G. HENRY MUNDT, Chicago: I would like to amend the motion, that the Presidents and Secretaries of County Societies, and Miss Ann Fox, the Secretary of the Educational Committee, be allowed to remain. (Seconded by Dr. W. O. Thompson and carried). The motion as amended was carried.

(The Sergeants-at-arms inspected the room)

(The House went into executive session)

DR. GREENING: I make this final motion, that you adopt this report as amended with the deletion of the section as tabled. (Motion seconded by Dr. F. H. Muller, Chicago, and carried).

(The House rose from executive session.)

THE PRESIDENT: We will now have the report of Committee C.

COMMITTEE "C"

(Presented by Dr. C. Paul White)

The Chairman of this Committee wishes to express appreciation of the efficient services of Dr. Felts and Dr. W. O. Thompson. Dr. Robert Mustell was absent.

Committee on Cancer Control: The Committee wishes to commend the Committee on Cancer Control and their laudable professional educational program. But it does question the advisability of urging laymen to go directly to the cancer-diagnostic clinic rather than being referred by the family physician.

(DR. WHITE: I move the adoption of this portion of the report. Motion seconded by Dr. P. R. Blodgett, Chicago Heights, and carried).

Tuberculosis Control: This report is very comprehensive and informative. We do, however, believe that the control of tuberculosis lies in education rather than in legislation.

(DR. WHITE: I move the adoption of this portion of the report. Motion seconded by Dr. Frank Deneen, Bloomington).

DR. JAMES H. HUTTON, Chicago: I wish to discuss it because there is mention of BCG vaccine. I do not know anything about tuberculosis and do not care as far as my professional efforts are concerned. The use of BCG vaccine is being actively pushed in Chicago. Last year the University of Illinois teamed up with the Pope Foundation and got several hundred thousand dollars to manufacture BCG vaccine. It was distributed. I think there is a disagreement among experts as to the value of BCG vaccine and the place it should occupy in the control of this disease. I should not think of this except that only a few days ago Mrs. Pope was in the office complaining because the Illinois State Medical Society had not approved BCG vaccine.

In approving this report I will vote for its adoption but I wanted the House to understand tthat while we are not condemming it we are not approving the use of BCG vaccine.

(The motion to adopt this portion of the report was carried).

Committee on Venereal Disease Control: This report shows progress in the control of venereal disease and it is interesting to note the fine cooperation of the State Department of Public Health.

We do urge that the State as a policy, in cases inaccessible to venereal disease clinics, pay the physician on the indigent care level for his services as well as to furnish the medicines for the treatment.

(DR. WHITE: I move the adoption of this portion of the report. Motion seconded by L. J. Hughes, Elgin, and carried).

Committee on Military Affairs and Emergency Medical Service: It is the opinion of our Committee that this report is incomplete. In particular, it does not deal with the allocation of physicians in event of a national emergency.

The international situation is so serious that this committee has a very important function to perform.

In the next war, the casualties among civilians will probably be greater than those of the armed forces.

It is generally agreed that the number of physicians in military service in the first and second world wars was greater than need be.

In view of the recent demand for drafting all physicians to the age of 45 years, this committee believes all plans for medical service in a national emergency should be developed and directed by organized medicine itself in cooperation with the military authorities.

It is important that a comprehensive state-wide plan for the handling of medical problems in a national emergency be set up at once.

We wish to commend for its suggestion of changing the name of the committee to that of "The Committee on Military Affairs and Emergency Medical Service."

(DR. WHITE: I move the adoption of this portion of the report. Motion seconded by Dr. G. C. Otrich, Belleville, and carried).

Committee to the Veterans Administration: This is a factual report and the Committee notes with some concern that the care of veterans continues to entail a great deal of red tape without much reward.

(DR. WHITE: I move the adoption of this portion of the report. Motion seconded by Dr. O. W. Rest, Chicago, and carried).

Respectfully submitted,
(Signed) H. A. FELTS
WILLARD O. THOMPSON
C. PAUL WHITE, Chairman

(DR. WHITE: I move the adoption of the report as a whole. Motion seconded by Dr. L. O. Frech, Decatur, and carried).

COMMITTEE "D"

(Presented by Dr. Pliny R. Blodgett)

Committee on Rural Medical Service: This Committee of your State Society has done a remarkably fine job in meeting the challenge of the care of the sick in our rural areas. This is not the whole answer but is is in line with a definite plan that must be worked out in the overall problem. This Committee has brought into being a better understanding by a substantial section of our citizenship, the farm families of Illinois. The spirit of cooperation engendered between the State Agricultural Association and our Medical Society brings to organized medicine a new ally in our effort to keep American medicine in the field of private practice. Every member of the Committee is to be commended for this substantial contribution to the Illinois State Medical Society.

(DR. BLODGETT: I move the adoption of this portion of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

Crippled Children's Clinic Committee: We commend the activities of this fine Committee which has done so much to help this group of handicapped children to become an asset to Society. The cooperation of the county societies, our teaching institutions and hospitals sets a fine example of the unselfish public service that the Society with follow-through and teamwork is giving to our state.

(DR. BLODGETT: I move the adoption of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

Committee on Industrial Health: We commend this Committee for their appreciation of the overall picture of the worker in industry. The various problems and the possible further encroachment into the field of private practice must be watched continuously and every effort made to keep the workers properly informed on the evils and vices of socialized medicine.

(DR. BLODGETT: I move the adoption of this portion of the report. Motion seconded by Dr. W. E. O'Neil, Evanston, and carried).

Ethical Relations Committee: The fine deportment and amicable ethical relationship of our members to each other has given this committee very little to do, for which we may all shake hands and compliment ourselves on belonging to such a fine professional family.

(DR. BLODGETT: I move the adoption of this portion of the report. Motion seconded by Dr. F. H. Muller, Chicago, and carried).

Maternal Welfare Committee: The report of this Committee is a report of progress. As we progress in our efforts to practice better medicine year after year, our maternal and infant mortality and morbidity decreases. This is a tribute to the men in general practice who take care of the vast majority of these cases.

(DR. BLODGETT: I move the adoption of this portion of the report. Motion seconded by Dr. L. O. Frech, Decatur, and carried).

Respectfully submitted,
(Signed) J. E. FLEISCHNER
MATHER PFEIFFENBERGER
J. S. TEMPLETON
PLINY R. BLODGETT, Chairman

(DR. BLODGETT: I move the adoption of the report as a whole. Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

REPORT OF COMMITTEE ON REPORTS OF THE EDITOR, THE COMMITTEE ON SCIENTIFIC WORK, PRESIDENT OF THE WOMAN'S AUXILIARY, ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

(Presented by Dr. D. B. Freeman)

The Report of the Editor: The report of the Editor is most acceptable to this Committee. Too much praise and commendation cannot be given to all directly or indirectly responsible for the publication of the Illinois Medical Journal, which now is one of the outstanding journals of its kind. It has consistently improved both in appearance and content and its new features are most interesting and instructive.

The Committee is heartily in accord with the Editorial answer to the editorial which in the Journal of the A.M.A. relative to the Cooperative Medical Advertising Bureau and recommends that the policy of accepting advertisements in the Illinois Medical Journal be adhered to as now in force, irrespective of the Cooperative Medical Advertising Bureau.

The "News of the State" section is an excellent addition to the Journal and many interesting items could be sent in to the Journal from the secretaries of the county societies.

"Medico-legal Briefs" is another important addition, especially since there seems to be a wave of malpractice suits springing up recently. Perhaps more information on this matter could be given.

The Committee also endorses the remarks of the Editor relative to Mr. L. E. Malley who is in charge of the business matters relating to the publishing of the Journal, as well as the remarks relative to the Journal Committee and Editorial Board for their endeavors.

Last but not least, credit and commendation should be in large proportions given to the Editor himself.

(DR. FREEMAN: I move the adoption of this portion of the report. Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

Committee on Scientific Work: The Reference Committee desires to compliment the Committee on

Scientific Work for the fine program arranged at this meeting of the Illinois State Medical Society. The speakers and papers were well selected.

The General Assemblies have not been attended as well as deserved considering the excellent orations and papers given. This was especially true on Tuesday when Sectional meetings were also held. It was thought by the Reference Committee that it might be more advantageous to hold General Assemblies on two days and devote one day entirely to sectional meetings, sectional meetings being either half-day or continued throughout the day. This would increase the attendance at the sectional meetings as well as the general assemblies. This arrangement would also give more time and opportunity to visit the Scientific and Technical exhibits.

The Reference Committee suggests consideration of this by the next Committee on Scientific Work.

The quality of the Scientific Exhibits under the directorship of Dr. John A. Mart is of the same high calibre as in former years.

The Reference Committee suggests the continuation of the movie program.

This Committee deserves much commendation and thanks for arranging the program.

(DR. FREEMAN: I move the adoption of this portion of the report. Motion seconded by Dr. L. O. Frech, Decatur, and carried).

Report of President of the Woman's Auxiliary: The report of the President of the Woman's Auxiliary is accepted in full with profuse thanks for services rendered to the Illinois State Medical Society.

Of the many activities of the Woman's Auxiliary, the Reference Committee wishes to recognize several, such as the contribution of approximately $2500.00 to the Benevolence Fund, the large increase in membership, the extensive publicity and Public Relations programs, the placing of Hygeia in school libraries, hospitals and public reading places, and the compiling of information about the Auxiliary.

For their untiring efforts and substantial donations to this cause, they deserve wholehearted support and the gratitude of the Illinois State Medical Society.

(DR. FREEMAN: I move the adoption of this portion of the report. Motion seconded by Dr. C. Paul White, Kewanee, and carried).

Report of Advisory Committee of the Woman's Auxiliary: This Committee has served admirably and should be commended for their efforts.

Evidence shows that they have cooperated most heartily with the President and Officers of the Woman's Auxiliary. Since the Committee has functioned so well, no comment or recommendations are made by this Reference Committee except the following:

It has been suggested to this Committee that the annual meeting of the Auxiliary be held in the same hotel as the Illinois State Medical Society for convenience and as a means of increasing attendance at the meetings of the Auxiliary, if feasible.

(DR. FREEMAN: I move the adoption of this portion of the report. Motion seconded by Dr. E. W. Weld, Rockford, and carried).

Respectfully submitted,

(Signed) L. S. TICHY
BEN E. FILLIS
DARRELL H. TRUMPE
DAVID B. FREEMAN, Chairman

(DR. FREEMAN: I move the adoption of the report as a whole. Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

REPORT OF COMMITTEE ON MISCELLANEOUS BUSINESS

(Presented by Dr. A. J. Linowiecki)

This Committee was appointed to receive and report on the reports of the Committee on Nutrition, Report of the Permanent Historian, Committee on Medical History, Advisory Committee to State Commission on the Chronically Ill, and on other matters of business as referred by the President.

Committee on Nutrition: The work of this Committee is very important and should receive the fullest cooperation of the Society.

(DR. LINOWIECKI: I move the adoption of this portion of the report. Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

Report of the Permanent Historian: The Reference Committee recommends that this Committee be continued and the work carried to completion.

(DR. LINOWIECKI: I move the adoption of this portion of the report. Motion seconded by E. S. Hamilton, Kankakee, and carried).

Committee on Medical History: The Reference Committee commends the work of this Committee and recommends that it carry on to the completion of its task.

(DR. LINOWIECKI: I move the adoption of this portion of the report. Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

Advisory Committee to the State Commission on the Chronically Ill: The work of the Committee is commended and it is commended that a more detailed report be rendered for next year in order that the real importance of their work can be evaluated.

(DR. LINOWIECKI: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Resolution presented by Dr. E. H. Ochsner for B.S.N. Nursing Course: In the short time allotted the Committee feels that this resolution presents some merit, but all the ramifications which seem to arise in its practical application require much study and we recommend that a special committee be appointed to study this problem and report to the Council.

(DR. LINOWIECKI: I so move. Motion seconded by Dr. Frank Deneen, Bloomington, and carried).

Respectfully submitted,

(Signed) A. J. LINOWIECKI, Chairman
J. C. REDINGTON
J. H. EDGCOMB

(DR. LINOWIECKI: I move the adoption of the report as a whole. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Report of Committee on Resolutions

(Presented by Dr. R. K. Packard)

The first resolutions considered were related to Medical Benevolence. They are as follows:

No. 1.

Whereas, the Illinois State Medical Society has seen fit to establish a program of benevolence for the benefit of unfortunate members or their dependents, and

Whereas, a committee on medical benevolence has been elected by this House of Delegates to administer said program, and

Whereas, it is necessary to provide ample funds to fully carry on an ever-increasing load of benevolence, and

Whereas, said program has been, and is now, administered on a voluntary income basis and subscriptions to which fund have been, and in the future will probably be, inadequate particularly so in times of economic depressions, therefore

Be it resolved, that a yearly per capita tax of $2.50 be levied on all members of each and every component county medical society, and that said $2.50 be collected as part of the annual state and county dues; earmarked for and paid into the state benevolence fund to be used by the committee for economic relief of distressed members or their dependents, and

Be it resolved, that any and all voluntary contributions, whether from the Council of this medical society, organizations, or individuals be accumulated to set up a trust fund, or endowment, the income from which to be used when, and if, necessary to augment the yearly income from assessments, and

Be it resolved, that when, and if, such endowment, or fund becomes sufficiently large to furnish ample income to carry the program, that yearly assessments then be modified, and

Be it resolved, that any existing yearly surplus from assessments be transferred to the endowment or trust fund, and

Be it further resolved, that this program be established at such a time and in such a manner that assessments will accrue to the benefit of the program with the payment of the 1949 yearly state medical society dues.

No. 2.

Whereas, the Benevolence Fund of the Illinois State Medical Society based, as it is, on voluntary contributions of Society members and appropriations by the Council from the General Fund is wholly inadequate to properly administer relief to needy members, their widows, widowers, or their children, and

Whereas, the Benevolence Fund is a demonstration of a professional interest and brotherly love for unfortunate physicians,

Therefore, we the Henry County Medical Society petition the House of Delegates of the Illinois State Medical Society to enact the following resolution, namely:

> "Each Society of the Illinois State Medical Society shall assess $5.00 for each member, this amount to be over and above the regular dues payable to the Illinois State Medical Society, and this amount earmarked to the Benevolence Fund of the Illinois State Medical Society".

This paragraph shall be the second paragraph of Section six of Article six of the Constitution of the Society.

The Committee as a whole is unanimously in accord that we should establish an ample amount of money to take care of all our present needs, and we should also develop and establish a trust fund. The Committee would like to call your attention to the "fourth whereas" in this resolution that a statement was made that the funds appropriated have been and will probably be inadequate, particularly in times of economic depression. Dr. Hamilton, who is Chairman of the Finance Committee and Dr. Oscar Hawkinson, Chairman of the Committee on Medical Benevolence, both stated that up to the present time, sufficient money had been given to the Medical Benevolence Fund to care properly for, and give sufficient aid to those who are under care at the present time. They further stated that they have increased the benefits in the last few years due to the increased cost of living and that they are of the opinion that there will be a greater need for more money in the future to care adequately for the people who are benefiters under this fund.

In the portion of the resolution which refers to a yearly percapita tax of $2.50 levied on all members of each and every componetnt county medical society, the Committee recommends that that be changed with the insertion of five dollars in place of $2.50. That report of the Committee which is the second "Be it resolved" portion of the report relating to the statement that all voluntary contributions whether from the Council of the Illinois State Medical Society, organizations, or individuals be accumulated, and set up as a trust fund or endowment, the income of which is to be used, when and if it be necessary to augment the yearly income from assessments. Your Committee is of the opinion that this portion of the resolution should be changed to read, "that all funds collected for medical benevolence during a current year should be placed in the general fund of the Illinois State Medical Society, and that all moneys paid to recipients of the Medical Benevolence Fund be deducted and that whatever portion of the Medical Benevolence Fund remains in this account be set up into a trust." The Committee further recommends that that portion of the resolution to the effect that when the endowment reaches a certain stage where the income from the endowment will be sufficient to carry out the needs of the Benevolence Fund properly, that such assessments be discontinued or reduced.

The Committee further recommends that the Chairman of the Council appoint a committee consisting of five members, three to be appointed from the Council, and two from members of the Illinois State Medical Society, who are not members of the Council, and that this Committee be instructed to study various trust funds, management of trust funds, the expense of trust funds, and report back at the next annual meeting of this House their recommendations.

The Committee recommends that the last portion of the resolution should be put into effect with the payment of the 1949 dues.

(Signed) R. K. PACKARD, Chairman
W. W. FULLERTON

DR. L. O. FRECH, Decatur: Will you explain briefly about depositary methods.

DR. PACKARD: It is the recommendation of the Committee that all moneys taken in for the benevolent fund be deposited in the treasury of the Illinois State Medical Society, out of which fund they will pay all the bills for those people who need help and at the end of the year whatever is remaining of all such funds for medical benevolence be placed in an endowment.

DR. FRECH: Does that mean if somebody should die and should make the benevolence fund the beneficiary of his estate and leave $100,000 that would go into the general fund?

DR. PACKARD: Until the end of the year and then into the endowment fund for medical benevolence.

DR. FRECH: I think that any funds left by anybody deceased for the benefit of benevolence should not go into the general fund; it should go into a trust or trust company.

DR. L. J. HUGHES, Elgin: Why not put it in directly?

DR. PACKARD: Our reason for changing that was largely due to the fact that during the coming year at least, or during the present year, the people who run the finances have to pay the bills and must have a revolving fund out of which they can pay the bills that come to them. Dr. Hamilton was also present during the discussion of this point.

DR. HUGHES: They are not paid now out of the general fund.

DR. CAMP: Under the by-laws the benevolence fund is set up. Dr. Packard's recommendation would necessitate a change in the by-laws. The benevolence fund is a separate fund and none of it can be used except for benefits. As I understand him, this should go into the general fund of the Society for one year. To do that would necessitate a change in the by-laws which could not be done this year. If he would be willing to change that so it would go into the benevolence fund and could be taken from that fund to pay the bills, it could be approved now.

DR. PACKARD: I will accept the recommendation of the Secretary as an amendment.

DR. FRECH: That settles the point.

DR. PACKARD: I move the adoption of the resolution as amended. (Motion seconded by Dr. O. W. Rest, Chicago).

DR. OSCAR HAWKINSON, Oak Park: We tried for more than a year to carry on and increase this fund by popular subscription and we have gotten practically nowhere. That is unfortunate. Most of them do not seem to appreciate the needs of our fellows who are in hard straits. We do not seem to understand. These things could happen to anyone of us. None of us knows what can happen to us in another ten years. I suppose that to the group who owned New York, New Haven and Hartford stock it was as sound as the Rock of Gibraltar, and one morning they woke up and did not have a dime to pay for their breakfast. There is only one other way to get funds and that is by assessment. We appreciate what it costs us. We in Illinois have paid the lowest dues of any state in the union. I was ashamed to tell a lawyer friend of mine what our dues are. They are ten dollars a year. I would like the recommendation of Dr. Packard's Committee to pass, I think it is good. We need not expect to get much in the way of donations. No one is going to die and leave us anything. The first thing that any organization, any individual wants to do is to try to stand on his own feet. I hope you will adopt this resolution. It means every year we will get five dollars from each individual member. We will use what we need and the remainder will be put in a trust fund.

THE PRESIDENT: All in favor of the resolution as amended, signify in the usual manner. (Motion carried).

DR. PACKARD: Inasmuch as the House of Delegates has approved the recommendations in the first resolution as amended, your Committee recommends that this resolution No. 2 be not approved. (Motion seconded by Drs. Harlan English, Danville, and L. O. Frech, Decatur, and carried).

3. *Non-partisan Administration of the Illinois State Hospitals*

(See Page 69, July issue)

DR. PACKARD: It is the opinion of the Committee that we did not have sufficient information on which to base a recommendation. I move that the resolution be not approved. (Motion seconded by Dr. Charles Papik, Chicago, and carried).

5. *Advancement of the General Practitioner*

(See Page 69, July issue)

Dr. PACKARD: This resolution was presented to the Committee before there were any deletions. It is being presented to the House with the following paragraphs deleted:

Paragraph 6: *Whereas,* the present method of selection of medical students, which is based largely on academic record, is the subject of much controversy, and results in the elimination of many candidates who would make outstanding physicians, therefore

Be it Resolved that the House of Delegates of the Illinois State Medical Society request the Medical Schools of the State of Illinois:

1. To review critically their method of selection of medical students so that academic record will not be the only factor in determining admission to the Medical School, and good average students who have qualities which indicate that they will make good physicians be given an opportunity to study medicine.

The present sub-section 2 becomes 1, and 3 becomes 2. There was not complete agreement among the Committee as to what was done. Your Reference Committee recommends that we adopt all of this report including those portions that were deleted in my reading. The resolution then reads as first presented on Monday. (Motion seconded by Dr. G. C. Otrich, Belleville, and carried).

THE PRESIDENT: The next order of business is fixing the per capita assessment for 1949 annual dues.

DR. W. W. FULLERTON, Steeleville: I move

that we make our dues fifteen dollars ($15.00) to include the payments to the benevolence fund.

DR. OSCAR HAWKINSON, Oak Park: I second the motion; five dollars of this to be earmarked for the benevolence fund. (Motion carried).

THE PRESIDENT: We come to unfinished business. The Secretary has none on his desk.

DR. W. E. KITTLER, Rochelle: I would like to call your attention to a man who has been a delegate to this Society for 35 years and who has also been a member of the Council. He is not well and I think it would be nice to send him a telegram. I refer to Dr. Charles E. Wilkinson of Danville. I so move. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

THE PRESIDENT: Now we come to new business.

DR. W. W. FULLERTON, Steeleville: I wish to introduce the following resolution:

Whereas, this, the 108th meeting of the Illinois State Medical Society, is one of the best meetings in the history of the Society,

Whereas, the success of this meeting has been due to the untiring efforts of the committee on arrangements and to our most charming host, the Chicago Medical Society,

Whereas, the Palmer House has provided excellent hotel accommodations as our headquarters hotel and the Congress Hotel excellent headquarters for the Women's Auxiliary,

Whereas, the Woman's Auxiliary have extended a helping hand in making this meeting a great success and their contributions to the Benevolence Fund is indeed appreciated with many thanks,

Whereas, this meeting could not have been attractive without the quality and caliber of our speakers,

Whereas, the courtesy and colorful presentation of the scientific and commercial exhibitors have made this meeting extremely educational,

Be it Resolved, that the House of Delegates go on record as recommending that the 108th annual convention of the Illinois State Medical Society is the best educational and instructive meeting in the Society's history.

Be it Further Resolved, that the Committee on Arrangements, the Chicago Medical Society, the Palmer House, the Congress Hotel, Woman's Auxiliary, the speakers and the scientific and commercial exhibitors be given a vote of thanks and a copy of these resolutions.

I move the adoption of this resolution. (Motion seconded by Dr. E. E. Davis, Avon).

DR. CAMP: I would like to get the consent of the men who offer the resolution to add names of those who have aided in making this meeting a successful one.

DR. G. HENRY MUNDT, Chicago: I would suggest that we change commercial exhibits to technical exhibits.

(Motion carried).

DR. WARREN FUREY: I made a motion to defer action on the report of the Constitution and By-Laws Committee and on the report of the Reference Committee because it contained one suggestion to be acted on under new business. Dr. C. Paul White presented a resolution recommending that each member of the Society be assessed five dollars for the Benevolence Fund and that the paragraph containing the above be made the second paragraph of Section six of Article six of the Constitution of the Society.

The Resolutions Committee recommended that that change be not made. All that is necessary is to act on the motion previously made by Dr. Greening that the recommendations of the constitution and by-laws committee be concurred in.

The other proposed changes in the constitution and by-laws appear on Page 60 of the Handbook. It is proposed because of difficulty encountered in the office of the State Society to add the words "totally and permanently" before the word "disabled" in Article IV, Section 6, of the Constitution, Past Service Members, Page 4. I move that that change be approved. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

The second proposed change is in Chapter XI, Section 7 of the By-Laws (page 24). The section with the proposed change would read:

"A physician living on or near a county line may hold his membership in the county most convenient for him." I move that that section be amended as proposed. (Motion seconded by Dr. E. E. Davis, Avon).

DR. C. PAUL WHITE, Kewanee: I think some trouble can come out of that. I am secretary of a county society in which there are two counties. We would probably lose a number of our very good members to Peoria if that change were adopted. I do not think it is a good idea. I do not know how we are going to rule these men living close to the border or just how it would work out in individual cases. We have men in our society who could not be accepted in any other society. I can see how men who are not acceptable in one society might find a haven in another society. I am not sure that the phrase, "upon permission of the Society in whose jurisdiction he resides", should be left out. Most of our people are willing to accept a man who wishes to come in and attend our meetings. If he pays dues somewhere in the state that is sufficient. If we are going to permit a man to join whatever county society he wishes, we are going to have no control over our members. We need a little protection. I am not in favor of losing control of our societies downstate.

DR. RALPH P. PEAIRS, Normal: I thoroughly agree with Dr. White. I have had occasion in recent years to have had two instances of controversy which would apply to this change in the by-laws. One was an instance, as Dr. White said, where a man not agreeable in his own county went over to another county. You are just looking for trouble if you toy with this proposition. Recently we had a controversy between Tazewell and Peoria Counties. We had eight members of Tazewell County belonging to the Peoria society. That matter was adjusted when we sat around a table. If you change the present ruling you will break up the smaller societies.

DR. W. W. FULLERTON, Steeleville: I am not in accord with the proposed change.

DR. FUREY: I have no brief for this particular point. This was presented to the Constitution and By-laws Committee by a group that was deeply concerned. My recommendation was made because it had been approved by the Constitution and By-Laws Committee.

DR. CHARLES P. BLAIR, Monmouth: I am interested in this motion. Peoria and Tazewell Counties have experienced a controversy recently. As councilors of Districts IV and V, Peairs and I, met with them. These men were hot as individuals and the societies were hot. They did not understand the principles underlying this until they were explained to them in detail. I am sure they are all satisfied. The moment this amendment is passed some of them will leave Tazewell County, and Tazewell County will suffer a loss of membership. After all, your constitution says what? That county society shall be the judge of its membership. I am very much against the motion.

DR. R. K. PACKARD, Chicago: I move that the motion be laid on the table. (Motion seconded by Dr. O. W. Rest and carried).

DR. FUREY: In regard to the other recommendation of the Committee, that was contained in Dr. White's resolution. The Resolutions Committee did not recommend that the change be made in the constitution because there will be more changes necessary if and when a trust company is set up. I recommend that it be disapproved. (Motion seconded by Dr. W. E. O'Neil, Evanston, and carried).

DR. FUREY: I move the adoption of the report as a whole. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

THE SECRETARY: I have a letter signed by the President and Secretary of Woodford County Society asking that Dr. Ernest Ballard Pearson of Eureka be made an honorary member. Article V, Section 7 of the Constitution, *Honorary Members,* reads as follows:

> Honorary members shall be those physicians of Illinois or other states, territories, island possessions or foreign countries, who have risen to prominence in the profession of medicine and who may be elected by a nine-tenths vote of the House of Delegates present at any annual meeting.

It would be in order to give this man honorary membership.

DR. W. E. KITTLER, Rochelle: I so move. (Motion seconded by Dr. P. R. Blodgett, Chicago Heights).

(A standing vote was taken and it was unanimous).

THE PRESIDENT: The next order of business is the election of Emeritus Members.

THE SECRETARY: In addition to the list we have, a case was reported this morning by the Councilor of a district from southern Illinois, relative to Dr. Whiteside of Jonesboro, 75 years old and permanently disabled. I would like to have him included in this list.

DR. P. R. BLODGETT, Chicago Heights: I so move. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

THE SECRETARY: I have now the following list of applicants for Emeritus Membership:

W. T. Marrs, Peoria Heights, Peoria County
T. F. Hill, Athens, Sangamon County
Albert L. Stuttle, Williamville, Sangamon County
F. H. First, Rock Island, Rock Island County
J. W. Seids, Moline, Rock Island County
E. A. Soule, East Moline, Rock Island County
Charles George Smith, Altadena, Calif., Chicago Medical Society
Frederick C. Test, Chicago, Chicago Medical Society
Jonathan E. Waggoner, Chicago, Chicago Medical Society
Charles J. Kurtz, Chicago, Chicago Medical Society
Joseph H. M. Otradovoc, Chicago, Chicago Medical Society
William S. Jones, Redmon, Edgar County
F. M. Marstiller, Geneva, Kane County
Whiteside, Jonesboro, Union County

DR. BLODGETT: I move that these men be elected to Emeritus Membership. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

THE SECRETARY: I have the following list of applicants for Past Service Membership:

William Blender, Peoria, Peoria County
W. C. Mershimer, Shawneetown, Gallatin County
E. A. Green, Ridgway, Gallatin County
Gottfried Koehler, Bonita Springs, Florida, Sangamon County
Henry Barancik, Chicago, Chicago Medical Society
Edmund D. Loring, North Hollywood, Calif., Chicago Medical Society
Jerome F. Strauss, Chicago, Chicago Medical Society
Robert E. Moran, Chicago, Chicago Medical Society

DR. W. E. KITTLER, Rochelle: I move they be elected. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

DR. W. O. THOMPSON, Chicago: In the report which Dr. White made as Chairman of Reference Committee "C", it was pointed out that serious thought needs to be given to the relocation of medical personnel in the event of a national emergency. It is generally agreed that in case of war the civilian population will suffer more probably than the men in military service. I am sure that all physicians are willing and anxious to cooperate with the military to take care of us in the face of a national emergency. It is important that we look at this from a common sense point of view.

I should like to move that this House of Delegates go on record as follows:

1. As opposing the present plan to draft all physicians up to the age of 45.

2. As opposing any plan to draft physicians in any age bracket in which the rest of the population is not subject to draft.

3. As being in favor of the idea that all plans for procurement and assignment of physicians in the event of a national emergency be worked out by the American Medical Association in close cooperation with military authorities.

4. As being in favor of the idea to give medicine its proper status in the armed forces, and in particular to raise the rank of medical personnel, so that the Sur-

geon-General of the Army, Navy and Air Force would be given the rank of general, admiral and general respectively and be placed on the general staff.

I move the adoption of that portion. (Motion seconded by Dr. Harlan English, Danville, and carried).

DR. THOMPSON: I should like to move that we instruct our delegates to make this action of our House of Delegates known to the House of Delegates of the American Medical Association and recommend that they take similar action.

(Motion seconded by Dr. O. W. Rest, Chicago, and carried).

DR. R. F. MILLET, Macomb: You should add that special consideration be given to those in military service in the last war who are still under forty-five.

DR. CHARLES H. PHIFER, Chicago: If the House will review the action of the new committee on national emergency, serious consideration has been given to the statement just made in the last six months and a pattern dictated.

DR. CHARLES P. BLAIR, Monmouth: I am sorry to bring this up because it might be controversial, but I am instructed. We are approached on a new matter of policy of which the Educational Committee has knowledge. We were approached by a commercial organization, as a matter of fact an advertising agency, that will give us seven minutes three times a week on the air, paid for by the sponsor that will be more or less commercial with a product. That particular product is not one that could be criticized. His idea originally was that we should have a pediatric program. He would like to have a program known, for instance, as Dr. Neece's program. He would like to have the right group take it up. They are willing to pay for this. The amount is not known, neither is the sponsor. Before we take it up we want to have some confirmation. This might become a very great affair. We are going to consider it very thoroughly before doing anything. We would like to have the House hear him. Would you be willing or would you oppose giving ethical clearance we will say to a name that might be used on such a program if the Committee saw fit? Presumably it would start in September. We would like to have ethical clearance. You understand we have a tremendous package to sell. Our own Illinois State Medical Society or any other state society except Michigan, has never been put on the air as a body.

DR. WARREN FUREY: I have nothing to add. My only thought when I heard of it yesterday was that this was something that might be of tremendous importance. We cannot tell you whether it will be until we have had opportunity to study and find out what the program is. We felt in considering such a program that if the Committee saw fit to approve, we should have the approval of this House of Delegates not only for the Committee in performing such a feat but also to give clearance to the individual, so that he would not be charged with unethical conduct every other day. That is the prime purpose of Dr. Blair's report. If you have confidence in your Committee then that clearance should be given.

DR. HARLAN ENGLISH, Danville: I move that we give the Committee a vote of confidence. (Motion seconded by Dr. G. Henry Mundt, Chicago).

DR. W. E. KITTLER, Rochelle: As I understand it, this motion is to approve. I would like to suggest as this is not quite clear and there may be some difficulties arising in the future, that this be referred to the Council for further action.

DR. MUNDT: A vote of confidence of this type is given primarily to authorize the Committee to go forward and study the thing. Naturally that Committee, which is a Council Committee, will contact the Council.

DR. FUREY: I want merely to point out what Dr. Mundt said, the Educational Committee is a Council Committee. This vote of confidence enables us to carry on.

DR. KITTLER: I withdraw my remarks.

DR. BLAIR: We are a Council Committee, but this is not a question of what I ought to do, it is a question of ethics and we are asking you. You are the sole judge.

(The motion was carried).

DR. H. KENNETH SKATLIFF, Chicago: The motion of Dr. Thompson has pointed out the necessity of maintaining our integrity in the face of an emergency. I would like to add to that the thought that if any emergency exists for any length of time we must find some means of protecting our medical students, so that the schools can carry on. I would therefore move you, Mr. President, that our delegates to the American Medical Association be instructed to endeavor to have that body meet with the military authorities in the event of another emergency to the end that the medical students may be deferred so their studies may be continued. (Motion seconded by Dr. Karl Vehe, Chicago, and Dr. P. R. Blodgett, Chicago Heights, Illinois, and carried).

THE PRESIDENT: We come to a very important point in our deliberations. We have a new President to be installed. This Society is to be congratulated upon the selection of Dr. Percy E. Hopkins for the 109th President of this Society. He is a man well rounded in experience and judgment. He has served with distinction as a member of the Council and of many important committees. To this can be added many civic achievements which have aided in the recognition of organized medicine. It is with great pleasure that I present to you, Dr. Hopkins, the gavel. I pronounce Percy E. Hopkins the President of this Society for the next year.

DR. HOPKINS: Thank you Dr. Neece. I am grateful to you gentlemen for this honor. I assure you my efforts during this coming year will follow along the line of traditions and efforts that have been provided by the men who have held this office in the past. I bespeak your cooperation and promise that we will try to continue to maintain the Illinois State Medical Society at its high level. Thank you very much.

DR. H. KENNETH SKATLIFF, Chicago: I move we adjourn. (Motion seconded by Dr. W. O. Thompson, Chicago, and carried).

The House adjourned *sine die* at 1:05 P.M.

NEWS OF THE STATE



CHAMPAIGN

Physicians Honored.—Five physicians who have practiced medicine for at least thirty-five years were elected to emeritus membership in the Champaign County Medical Society at a dinner meeting May 13. The physicians are Doctors J. S. Mason and C. T. Moss, sr., both of Urbana; W. E. Schowengerdt, Champaign; L. O. Sale, Fisher; and P. C. Casto, St. Joseph. Guest speaker at the meeting was Dr. Louis W. Nie, Bloomington-Indianapolis, on "Emotional Reactions in Chronic Disease."

CLINTON

Dr. Roane Honored.—Dr. J. Q. Roane, Carlyle, was honored at a dinner Sunday evening, May 23, by the Clinton County Medical Society. Dr. Roane was presented with a gold emblem and certificate indicating membership in the Fifty year Club of the Illinois State Medical Society. Dr. Irving H. Neece, Decatur, immediate past president of the Illinois State Medical Society, made the presentation. Dr. Neece's talk was a skit in the form of a court summons with Dr. Roane as the main target in a list of charges. With a declared verdict of "guilty" for Dr. Roane, Dr. Neece said, "And forthwith sentence you to the continuing love and loyalty of the vast host of friends whose lives your own life has touched, inspired and blessed." Dr. M. A. Bateman, Carlyle, president of the Clinton County Medical Society, presented the honored guest with a billfold as a token of esteem of the society. Graduating at Missouri Medical College, now called Washington University School of Medicine, St. Louis, Dr. Roane started the practice of medicine in Ina, Ill. He subsequently practiced in Boulder for six years. Dr. Roane was secretary of the Clinton County Medical Society for twenty-five years. He also served as Councilor of the Illinois State Medical Society. He was, for many years, a member of the Carlyle board of education and also director of the Carlyle Building and Loan Association as well as director of the First National Bank in Carlyle.

COOK

Loyal Davis Named Chief of Staff at Passavant.—Dr. Loyal Davis, chairman of the division of surgery, Northwestern University Medical School, has been named chief of staff of Passavant Memorial Hospital, succeeding Dr. Howard Carroll.

The Borden Award—Dr. Ben Fisher of Milwaukee, Wis., has been named the winner of the Borden Undergraduate Award for 1948 at the University of Illinois college of medicine.

The award to Dr. Fisher represents a gift of $500. The Borden Company recently presented $2,500 to the University of Illinois College of Medicine for the award over a period of five years.

Dr. Fisher has published three articles on prothrombin tests, and is actively pursuing research at the present time. He received his doctor of medicine degree from the University of Illinois earlier this month.

Gift for Study on Allergy—The Asthmatic Children's Aid has presented a gift of $10,000 to the University of Illinois colleges of medicine and pharmacy for investigative work in allergy.

The gift was presented to the University on July 8, by Mrs. M. Morton Strassman, 751 Junior Terrace, retiring president of the Asthmatic Children's Aid. It was received in behalf of the University by Dr. Earl R. Serles, dean of the college of pharmacy, and Dr. John B. Youmans, dean of the college of medicine.

The Asthmatic Children's Aid has now contributed almost $40,000 to the University of Illinois' Allergy Unit since it was established in November, 1944.

Work Begins on a Betatron for Cancer.—Groundbreaking exercises to house a betatron for cancer treatment and research were held June 18 on the campus of the Chicago Professional Colleges, University of Illinois College of Medicine. The site for the new building is between the power plant and the nurses' home. Ground was broken by Governor Dwight H. Green. Dr. George D. Stoddard, president of the University, Professor Donald Kerst, the inventor of the betatron and Dr. Roger A. Harvey, head of the department of radiology at the Chicago Professional Colleges, gave short addresses. The unit is the world's first installation of a betatron for cancer treatment and research with the University of Illinois College of Medicine becoming a pioneer in the medical use of this instrument.

Research in this direction was delayed during the war while attention was centered on using the betatron for industrial x-ray work. A push-button controlled instrument producing 20-million volt x-rays was developed by University scientists and the Allis-Chalmers manufacturing company of Milwaukee.

One of these will be installed at the College of Medicine. Delivery is expected in approximately five months. Dr. Harvey will be in charge. Because of tests and developmental work necessary with this entirely new type of cancer weapon, it is unlikely that any patients will be treated until some time in 1949.

X-rays now used in hospitals for treating deep cancers are of 200,000 to 2-million volts energy. The 20-million volt betatron may in the future become standard for deep treatment after the way has been blazed by the University.

Prof. Kerst's first instrument in 1940 produced 3-½-million volt x-rays. Within a year he had a second instrument producing 20-million volts. This became the prototype of the industrial betatron, such as is to be installed at the medical school. Now he is building a 300-million volt betatron for physics research, to produce cosmic ray effects in the laboratory and open entirely new doors to science.

Tests by Prof. Kerst and associates have proved that 20-million volt x-rays not only have great energy, but also will have the medical advantage of concentrating more effect inside the subject rather than on the surface. X-ray now used medically have their greatest effect at the point of entry into the body, and only a small decrease to the point of exit.

The Illinois scientist, using material which absorbs rays equally with a living body, has found that 20-million volt x-rays have their greatest effect approximately 1-1/2 inches (3-4 cm.) inside the surface, and that after passing through 8 inches (20 cm.) of the material their energy is only about one-half that of the maximum point. The 8 inches corresponds to an approximate thickness of the human body.

This means for medicine that surface damage, at points where the ray beam enters and leaves the patient, will be less, and at the same time that the x-ray dosage is concentrated in maximum on the deep internal organs where it is desired. The betatron has other advantages in easy and precise control of energy produced, and in a very narrow, sharply-defined ray beam.

While 20-million volt x-rays are many times more penetrating than those now used medically, tests by Prof. Henry Quastler of the University's physics staff at Urbana-Champaign with the 20-million volt betatron there have shown that no new or unusual dangers result from the greater energy.

Prof. Quastler now is working on a diaphragm for the beam to control the small amount of scattering of x-rays and electrons. Control of these is one of the developmental problems to be worked out before the betatron can be used for treatment of patients.

The new betatron will be housed in a small building to be erected south of the University's Research and Educational hospitals. The building will provide space for the machine and for patients. The building will measure 26 by 48 feet, and will contain a magnet room, control room, mechanical equipment room, and a transformer vault.

Most of the structure will be underground so that the surrounding earth will provide an x-ray barrier. A tunnel will connect the building with the hospital.

A 20-million volt betatron is not much larger than an office desk. It is 36 inches wide and 81 inches long. A base, lifting the machine so that the beam comes out at a convenient working height, puts the top of the machine 84 inches from the floor. It weighs 5-1/2 tons. A condenser bank and a control panel which weigh an additional 5 tons complete the equipment.

The main part of the betatron is an electromagnet, between whose circular pole faces is a doughnut-shaped porcelain vacuum tube 19 inches in diameter. Electrons released in this tube are accelerated by the field of the alternating current powered magnet.

In 1/720 of a second the electrons spin 300,000 times around inside the vacuum tube, travelling 250 miles, and attaining a volocity just short of the speed of light, 186,000 miles per second. Then they are deflected to strike a platinum target. Bombardment of the target by the electrons produces the x-rays.

The high-energy electrons themselves have great possibilities for cancer treatment. They offer the possibility of even greater concentration of effect at a point inside the body, and of completely using up their energy at that point so that none go on to an exit. A beam of electrons can be produced from the industrial type betatron simply by changing vacuum tubes, replacing the one having an x-ray

producing target with one having a "peeler" to bring out the electron beam.

Use of electrons in medicine is one of the great future possibilities of the betatron, but as it involves several still only partly explored factors, it is farther away than use of the x-ray beam. Dr. Harvey has indicated that first use of the new instrument at the University of Illinios College of Medicine will be with the better known x-rays.

The electron beam is of special interest to Dr. Lester S. Skaggs of Michael Reese hospital staff in Chicago, who has been at the University of Illinois campus in Urbana-Champaign since 1945 working with the betatron there. He headed the research team which in 1946 developed the "peeler" bringing the electron beam out of the machine.

This was the first step toward making the electrons available for cancer treatment. It is estimated that at least a year of intensive study by medical scientists will be necessary before they can be safely used on a human being. Such research now is handicapped by lack of a betatron available full time for medical purposes.

Vermont Physician Joins Illinois Staff—Dr. John P. Marbarger of the University of Vermont has been appointed director of research for the University of Illinois' new Aero Medical and Atmospheric Institute.

Dr. Marbarger, a former Army captain, was assigned to the U. S. Air Force' Aeromedical laboratory at Wright Field, Dayton, O., from 1943 to 1946. During that period, he conducted research in the fields of pressure breathing and thermal regulation under extreme environmental stress.

Dr. Marbarger, in addition to his duties as director of research for the Institute, has been appointed associate professor of physiology in the college of medicine. He assumed his new duties on July 1.

Dr. Marbarger, 33, has been serving as assistant professor of physiology at the University of Vermont, at Burlington. He is a graduate of Lebanon Valley College, Annville, Pa., and Johns Hopkins University, Baltimore, Md.

Married and the father of three children, he now resides at Fort Ethan Allan, Vt. He is a native of Palmyra, Pa.

Students Honor Instructors.—Seniors at the University of Illinois College of Medicine have named Dr. Henry G. Poncher and Dr. Eric Oldberg as the 1948 winners of the Raymond B. Allen Instructorship award. The award is designed to honor excellency in individual instructorship rendered by faculty members to the students. Dr. Poncher, head of the department of pediatrics, was honored for clinical instruction. The award for excellency in didactic instruction has been given to Dr. Oldberg, head of the department of neurology and neurological surgery. The junior, sophomore, and freshman classes in medicine also have named the recipients of instructorship awards for 1948. They are: Junior class—Dr. Poncher for clinical instruction and Dr. Isadore A. Rabens, clinical associate professor of medicine, for didactic instruction. Sophomore class—Dr. Carl C. Pfeiffer, head of the department of pharmacology and pharmacognosy. Freshman class—Tie between Drs. William J. Furuta and Parke H. Simer of the department of anatomy.

Society News.—Dr. Philip Thorek presented a paper on "Surgical Therapy in Gastroduodenal Ulcer" before the thirteenth annual convention of the National Gastroenterological Association in New York, June 7, showing also a colored motion picture. He also addressed the ninety-fifth annual session of the Minnesota State Medical Association in Minneapolis, June 8, on "Acute Abdominal Pain."

Personal.—Dr. Max Thorek received the Honary Fellowship of the Roman Surgical Society as well as the Honorary Fellowship of the Piedmont Surgical Society and the Brazilian College of Surgeons during the recent meeting of the International College of Surgeons held in Rome, Italy, from May 16-23—Dr. Sol R. Rosenthal, assistant professor of bacteriology and public health at the University of Illinois College of Medicine, attended the First International Congress of BCG in Paris, June 18-23. Dr. Rosenthal presented three papers before the congress on a new method of vaccinating, a new method of preserving BCG, and the results of BCG studies in Chicago. He also served as vice president of a section on human vaccination. The First International Congress of BCG was sponsored by the Institute Pasteur of Paris.—Roy W. Walholm, Winnetka, has been named executive vice president of Evanston Hospital, a newly created position in which he will organize and direct extensive plans for expansion of the hospital. Mr. Walholm is co-founder and director of Industry for Veterans, established in 1945 for the purpose of soliciting industry's pledges of work for the returning service men.

University Lecture.—Dr. Lester R. Dragstedt, professor of surgery, University of Chicago School of Medicine, gave an assembly hour lecture at the University of Illinois College of Medicine May 5, 1948 on, "The Pathogenesis of Peptic Ulcer."

DU PAGE

Prepaid Hospital and Medical Care Plans.—The May 19 meeting of the Du Page County Medical Society at the Du Page County Memorial Hospital in Elmhurst, was devoted to a consideration of prepaid hospital and medical care plans by the following speakers: Edwin F. Keicke, president of the board of trustees, Memorial Hospital of Du Page County; Leo M. Lyons, director, St. Luke's Hospital, Chicago; C. Norman Andrews, assistant director, The Chicago Blue Cross Plan for Hospital Care; Frank F. Selfridge, president of the board of trustees, Highland Park Hospital, Highland Park; Frank E. Smith, Associated Medical Care Plans, Chicago; and Dr. E. H. Droegemuller, member of the medical staff, Memorial Hospital of Du Page County.

FULTON

Nursing as a Career.—Dr. Charles P. Blair, Monmouth, Chairman of the Educational Committee and Councilor of the Fourth Councilor District of the Illinois State Medical Society, gave the principal address to the graduating class of nurses of the Graham Hospital, Canton, June 25. Dr. Blair's subject was "Nursing as a Career." Dr. Everett P. Coleman, Canton, is chief of staff of the hospital.

HENRY

Election of Officers.—Dr. A. W. Wellstein, Geneseo, was chosen president of the Henry County Medical Society at its annual dinner meeting, May 3. Other officers are Dr. Nolan G. Montgomery, Kewanee, and Dr. C. Paul White, Kewanee, was re-elected secretary-treasurer. Dr. Gidon Hoffman, Kewanee, was presented with an emblem and certificate indicating membership in the Fifty Year Club of the Illinois State Medical Society.

LA SALLE

Society News.—Dr. Frederick W. Munson, Oak Park, addressed the Streator Medical Society, May 26, on "Compound Fractures." Dr. Munson formerly lived in Streator but is now specializing in Surgery in Chicago.

LAWRENCE

New Health Board.—Roy R. Rucker, Bridgeport, editor of the Bridgeport Leader, was elected president of the Lawrence-Wabash County Health Board recently, succeeding Justus Gibson, county superintendent of schools of Wabash County. Mr. Gibson will continue his service to the board as secretary. Dr. L. C. Baldwin, Sumner, is treasurer. Other members of the board are Dr. Tom Kirkwood, Lawrenceville, Mrs. Oliver Clawsen and Dr. Benjamin Stein.

LIVINGSTON

Society Reelects Officers.—At a recent meeting of the Livingston County Medical Society at the Dwight Woman's Reformatory, the following officers were reelected: Dr. Andrew J. McGee, Dwight, president; Dr. Harold Schroeder, Pontiac, vice president; and Dr. Otis Law, Pontiac, secretary-treasurer.

LOGAN

Fifty Years of Practice.—Dr. L. L. Dennison, Lake Fork, has completed fifty years in the practice of medicine. The physician was born January 6, 1868 in Bornsville, W. Va. He graduated at the Louisville Medical College in 1897. After a year's hospital work in Louisville, Dr. Dennison took his state examinations in Springfield, subsequently beginning practice in Lake Fork. He has practiced there ever since.

MACON

Dr. Neece Among Speakers for Chamber of Commerce.—Dr. Irving H. Neece, Decatur, immediate Past President of the Illinois State Medical Society, is the only physician among a group of speakers who are available before service clubs and civic organization. The information appears in a list prepared by the local Association of Commerce, according to the Decatur Review.

MCLEAN

Physician Named Head of Health Council.—Dr. Thomas D. Fitzgerald, staff physician at the University State Normal School was elected president of the McLean County health council, May 24. Other officers chosen were Dr. Walter J. Broad, director of the McLean County health department, vice president; and Miss Dorothy Worst, staff nurse, secretary-treasurer. The meeting, at which the election was held, was addressed by Dr. Ralph Peairs, Normal, Councilor of the Fifth District of the Illinois State Medical Society.

PEORIA

Eldred Musson New Health Commissioner.—Dr. Eldred K. Musson, health officer of the newly organized Schoharie County Department of Health in New York, was to take over the health commissionership of Peoria, July 15. Dr. Musson succeeded Dr. E. V. Thiehoff, resigned. Dr. Musson graduated at the University of Kansas School of Medicine in 1928, interning at the Kansas City General Hospital. After two years service as county and district health officer, he became a Rockefeller Foundation Fellow at the Harvard School of Public Health where he received his Master of Public Health degree. He subsequently served as director of local health work of the Missouri State Department of Public Health. He then became director of preventable diseases of the Kansas State Board of Health where he remained until 1931. He then joined the Chicago Board of Health as chief medical officer. He later entered the U. S. Public Health Service and served four years on foreign duty.

PIKE

Society News.—At a joint meeting of the Pike-Calhoun County Medical Societies, Thursday evening, May 27, in Pleasant Hill, Dr. George L. Drennan, Jacksonville, discussed "Recent Advances in Pediatrics" covering particularly surgical treatment for congenital heart diseases. Dr. Drennan is a member of the Educational Committee of the Illinois State Medical Society.

RANDOLPH

Six County Meeting.—The Six County Medical Society was addressed at the Security Hospital, Chester, July 22, by Drs. J. Byron Beare, St. Louis, on "Bladderneck Obstruction"; Carl A. Wattenberg, St. Louis, on "Medical and Surgical Treatment of Urinary Calculi." A business session concluded the program. The Randolph County Medical Society, of which Dr. W. W. Fullerton, Steeleville, is secretary, was host.

ROCK ISLAND

Dr. Liberman Goes to California.—Dr. Herbert H. Liberman, who has been practicing pediatrics in Moline for the past twelve years, has gone to California to engage in the practice of medicine, according to the Moline Dispatch.

ST. CLAIR

Personal.—Dr. Fred E. Rose, certified by the American Board of Internal Medicine, has been appointed to a three year term as a member of the board of directors of Pleasant View Sanatorium, succeeding Dr. Edmond Bechtold who resigned because of illness. Both are of Belleville.

SANGAMON

Election of Officers.—Dr. Oliver E. Ehrhardt was chosen president of the Sangamon County Medical Society, June 3, succeeding Dr. Kenneth R. Schnepp. Other officers are Drs. David J. Lewis, vice president; M. E. Rolens, censor, and Jacob E. Reisch and Darrell H. Trumpe, delegates to the Illinois State Medical Society. Dr. William DeHollander was reelected secretary.

SHELBY

Ninety-Three Years of Age.—Dr. J. C. Westervelt, Shelbyville, observed his ninety-third birthday, June 7. Dr. Westervelt graduated at the Bennett College of Eclectic Medicine and Surgery in 1877, beginning the practice of medicine in Shelbyville the following year.

VERMILION

Danville as a Medical Center.— An attractive booklet entitled "Danville as a Medical Center" was published by the Vermilion County Medical Society: "As a higher and higher premium is is devoted to the theme "Your Health — It Must and Shall be Preserved!" Following the introduction on the purpose of the booklet, sections are listed with the following titles: The Hospitals, Services Available in Danville Hospitals, Special Clinical Service and Blood Bank, Insurance Against Hospital and Doctor Bills, and Nursing Education in Danville Hospitals. Under each heading, independent units making up the whole are discussed briefly and identified. The booklet concludes with the following message from the Vermilion County Medical Society. "As a higher and higher premium is placed on health, the necessity of providing more facilities for medical, obstetrical, surgical and hospital care is increasing. The staffs of specialists, the directors, both are doing everything possible to provide these facilities for the use of more people in the community — a community which is not bounded by county or state lines. These men and women, the guardians of your health, are aware of changing needs. They are qualified, adaptable and progressive enough to meet these changes. Ask YOUR doctor for his opinion of the relative value of medical, surgical, obstetrical and special services available in this city. He will tell you this — and it's worth remembering: 'The types of such services available anywhere else in the United States are available in Danville, YOUR MEDICAL CENTER!'"

WINNEBAGO

Personal.—Dr. Robert M. Lewis, who has been associated with Dr. C. L. Leonard and Dr. F. F. Folmer in Rockford, has opened his own offices to practice independently.

Discontinue Summer Ban on Tonsillectomies.— The Winnebago County Medical Society went on record May 21 in favor of discontinuing the summer ban on tonsillectomies, according to the Rockford Star. The ban was placed in effect during the poliomyelitis epidemic during 1945 and was observed through July to October in both 1946 and 1947. While it was in effect, the ban was "95 per cent observed" and tonsillectomies were authorized only in serious cases and emergencies. This year the society named Dr. T. F. Krauss, chairman, and Doctors J. H. Garthe, C. B. McIntosh, J. J. Potter and Justin Steurer to a committee to investigate continuance of the ban. The recent action of the society was finally taken after information was received from Dr. John R. Paul, director of the poliomyelitis research, Yale University Medical School, New Haven, Conn. According to the Rockford Star, Dr. Paul pointed out that no positive relationship between poliomyelitis and recently tonsillectomized persons has been found. He also stated that since there has been an absence of major polio epidemics since 1945, he "could see no good reason why the ban should be continued." At this meeting, Dr. R. E. Heerens, Rockford, spoke on "Practical Application of Skin Flaps."

GENERAL

District Association Officers.—Dr. H. P. Miller, Rock Island, was elected president of the Iowa-Illinois Central District Medical Association at its annual meeting May 26, in the Hotel Blackhawk, Davenport. Officers include Dr. A. Walter Wise, Rock Island, first assistant secretary; Dr. F. E. Bollaert, East Moline, treasurer; Dr. Sam Durr, Rock Island, censor, for a two year term. Dr. Phebe Pearsall-Block, Moline, presented a fifty year button to Dr. Hada Carlson, Moline, chief medical officer of the Royal Neighbors of America. Another fifty year button was presented to Dr. J. H. Seids, Moline, by Dr. D. B. Freeman, Moline.

Illinois Clubwomen Renew Cancer Research Grant to N.U.—Dr. William B. Wartman, Morrison professor of pathology and chairman of that department in the Northwestern University Medical School, has announced that the Illinois Federation of Women's Clubs has renewed its grant of $2,000 annually to the pathology department for cancer research. The women's organization originated the grant several years ago.

Recently Dr. Wartman was appointed to the committee on pathology of the division of medical sciences of the National Research Council, and was also given a certificate naming him a corresponding member of the medical association of Argentina in the division of normal and pathological anatomy.

Warning on Gastrointestinal Disturbance.—The Cook County area may be faced with a new form of severe gastrointestinal disturbances, according to a statement issued July 2 by Cook County Coroner A. L. Brodie. Coroner Brodie stated that the interest of his office in this problem began with the investigation of a death in a 58 year old Cook County resident, who died at Cook County Hospital following a sudden illness after the ingestion of an uncooked bologna sandwich. Dr. J. J. Kearns, Coroner's Pathologist working with Dr. Edward A. Piszczek, Director, Cook County Department of Public Health, and the Chicago laboratories of the Illinois Department of Public Health reported today that the examination reveals the presence of "Proteus Mirabilis" organisms. Proteus Mirabilis organisms have been suspected for a long period of time of being the causative factor for gastrointestinal disturbances, but have been definitely proven for the first time to be such by the Naval Medical School in the study of an outbreak reported in May, 1946

In its report to Dr. Edward A. Piszczek, the Chicago Laboratory of the Illinois Department of Public Health stated that this organism first made its appearance in this area just a short time ago, and during the past month about eight specific cases of laboratory specimens sent in for food poisoning investigation contain the organism of Proteus Mirabilis. The reported clinical symptomatology produced by an attack of these germs was characterized by an onset of severe abdominal pain with diarrhea and cramps within 3 to 9 hours after ingestion of food. Many of these cases are so severely affected that they require hospitalization and the administration of intra-venous fluids to reduce the toxicity of the diseases. All patients had severe nausea and vomiting, nearly all gave a history of continual emesis in the acute stage which resulted in bile tinged ejecta followed by water fluid. Many of the vomitus and stool specimens contained blood. The average length of illness was about 40 hours.

The death of this 58 year old man apparently is the first death from this specific organism reported in medical literature. Although, this organism has been suspected of being a possible causative organism of similar fatal attacks.

The prevention of this infection, according to the Coroner, is a public health food handling problem. Consistent good practices in food sanitation is not only the preparation but the handling, refrigeration and adequate preparation of food for human consumption will do a great deal to prevent the occurrence of this disease. The meticulous handling of hands especially after handling soil or organic matter of animal origin is a primary essential in the prevention of these outbreaks of food poisoning.

Survey on Rheumatic Fever.—June 7 marked the opening of a survey to study the history and causes of specific cases of rheumatic fever by the Rheumatic Fever Research Institute of Northwestern University Medical School. More than fifty volunteer case workers who enlisted in a house to house canvass, which was estimated to cover 10,000 homes and 50,000 persons living within 150 blocks of the Bridgeport area in Chicago, in an attempt to locate new cases. The district to be surveyed is bounded on the north by the river, on the south by 39th Street, on the west by Ashland Avenue, and on the east by the Pennsylvania railroad tracks running beside Stewart Avenue. It is anticipated that at least 1,000 active cases of the disease will be found but the purpose was always to learn whether any living members of the homes visited ever had rheumatic fever before at any time. It was planned to send any active cases discovered during the two-week survey to rest homes or be given ambulatory treatment at a rheumatic fever clinic established by the Northwestern Institute in the neighborhood Salvation Army center. Accumulated data will be studied by Dr. Alvin F. Coburn, director of the institute, and his staff during the summer, and a follow-up system to keep in touch with any active cases among children will be ready to function by the time school opens, it is anticipated. The Rheumatic Fever Institute was recently established with Dr. Coburn as its head. Six physicians and nine assistants already are on the staff which will be augmented as rapidly as possible. Four laboratory units have been started. The institute will collaborate with LaRabida Sanitarium, the convalescent home; Cook County and the Children's Memorial Hospital, and the Great Lakes Naval Training Station where rheumatic fever is a perennial problem among young recruits. The Navy has given $75,000 to the institute, while $90,000 has come from the U. S. Public Health Service. Individuals and organizations on the Atlantic seaboard have sent another $263,000, enough to get the project under way. Budget for the next ten years is $1,875,000.

Lake Michigan Bathing Water Survey.—A comprehensive tri-state survey of Lake Michigan waters with special reference to bathing, is being made by the Illinois, Indiana and Wisconsin State Health Departments, local governmental health agencies, and coordinated by the United States Public Health Service. The project extends from Milwaukee, Wisconsin, to Michigan City, Indiana.

The objectives of the survey are:

(1) To determine the physical, chemical, and bacteriological conditions of the waters tributary to and at the bathing areas.
(2) To investigate the physical factors which influence the changes in water quality.
(3) To study the effects of bathing loads on water quality.
(4) To secure epidemiological data on diseases or irritations attributable to bathing which may lead to the establishment of more definitive water cleanliness standards.

To accomplish these objectives field parties under the direction of sanitary engineers from the State Boards of Health and U. S. Public Health Service

will make sanitary surveys of sewage and waste disposal and will study hydraulic and hydrological data. Samples of Lake Water will be collected and examined for coliform and enterococcus (streptococcus) organisms which are indicative of pollution, in a number of laboratories in each of the three states.

The Chicago Park District will furnish data upon bathing beach loadings throughout the survey and will assist in sample collections.

Two areas in Chicago have been selected where a concentrated epidemiological study will be carried on by the Illinois Department of Public Health, city and county health officials and the Chicago Park District. The north side area is bounded by Farwell to Loyola Avenues and Lake Michigan to Lakewood Avenues; on the south side from 73rd to 76th Streets and Lake Michigan to Coles Avenue. In each area 100 families will be asked to cooperate by recording on a calendar form any unusual reactions to bathing or any symptoms of illness, such as eye, ear, nose, throat, skin infections or gastrointestinal upsets.

The purpose of this survey is to secure reliable information on the physical effects to human beings, if any, of swimming in Lake Michigan. To accomplish this two items are especially important. First, a sufficiently large population group must be surveyed to give significant results; and second, the entries on a calendar form by the householder must be carefully made each day.

Medical students and public health nurses began June 28 to do a house-to-house canvass in the two selected areas. Persons who swim in Lake Michigan as well as those who do not are being asked to keep a daily record of illnesses. The survey is concerned not only with significant illnesses that will require a physician's treatment but with minor illnesses that occur during the summer that the doctor will never be called upon to diagnose.

From time to time participants will be contacted by telephone or by another home visit.

Physicians are urged to cooperate every way possible. Any unusual incidence of illness that may be due to swimming should be reported to the Bathing Water Survey Committee, Chicago Park District, Attention, Dr. L. B. Gordon, Harrison 5255.

Cancer of the Oral Cavity.—An evening postgraduate course of six lecturers designed to present recent advances in cancer of the oral cavity will be offered again by the University of Illinois College of Dentistry, in cooperation with the Illinois division of the American Cancer Society, Illinois State Dental Society, and the Illinois State Medical Society beginning Wednesday, October 6, 1948.

The course has been organized in response to the growing recognition of the need for early oral diagnosis in cancer control.

Dr. Bernard G. Sarnat, head of the department of oral and maxillofacial surgery, will be in charge of the course. The course will be offered over a period of six consecutive Wednesdays from 7:30 to 9.30 p.m. Arrangements for the transmission of these lectures by telephone are being considered for groups of dentists and physicians who reside outside of Chicago.

The course will place emphasis on the characteristics and differential diagnosis of oral lesions and will include consideration of public health aspects, cancer research, surgical and radiation treatment, and surgical and prosthetic reconstruction. The final period on November 10, 1948, will be devoted to a round table discussion.

The tuition charge for the course has been waived, through the courtesy of the Illinois division of the American Cancer Society.

Further information and registration for the course may be obtained by writing Dr. Isaac Schour, associate dean in charge of postgraduate studies, of the college of dentistry, 808 S. Wood street, Chicago 12, or calling him at MONroe 3900, extension 491. Applications will be accepted in the order in which they are received.

FROM THE DEPARTMENT OF HEALTH

Ground-Breaking Ceremonies for New Hospital.—On June 11, ground breaking ceremonies were held in Flora to mark the start of the construction of the first hospital in the middlewest to be built entirely under the provision of the state-federal hospital program, according to Dr. Roland R. Cross, state director of public health and state administrator of the hospital program. Dr. Cross turned the first spadeful of earth in the ceremonies under the hospital construction program. An amount up to one-third the cost of local public and non-profit hospital projects can be paid from federal funds. Also, not more than one-third the cost of an approved project can be allotted from the state appropriation of $4,850,000 passed by the 65th General Assembly. A 50-bed public general hospital, to be owned and operated by Clay County, the new building at Flora will be constructed at an approximate cost of $725,000. Funds in the amount of $237,000 will be provided by the Federal government and approximately $230,000 will be paid from the State appropriation. The remainder of the construction costs will come from local funds available as the result of a bond issue approved by the voters of Clay County and from contributions by the community. The new hospital is to be a fire-proof, one story building construced of concrete and steel. In addition to beds which will be available for medical, surgical and maternity patients, the new structure will be equipped with X-ray facilities and modern treatment and examining rooms.

Increase in Undulant Fever.—Morbidity statistics released recently by Dr. Roland R. Cross, State Director of Public Health, showed a steady rise in the reported prevalence of undulant fever in Illinois.

"Ever since the first cases of undulant fever were reported in the State in 1927, the general trend has been toward a higher and higher annual incidence

of disease," Dr. Cross said. He cited figures showing that only 5 cases of undulant fever were reported in Illinois in 1927. By 1935 the number had risen to 144; in 1938 it reached 216; and by 1943 it passed the 300 mark. Last year, 553 cases were reported, the highest incidence of undulant fever ever recorded in any one year.

During the first 24 weeks of this year 232 cases of undulant fever were reported to the State Department of Public Health, as against 223 cases for the comparable weeks of 1947. That the disease is more prevalent in rural areas of Illinois is indicated by the fact that only 8 of the 232 cases reported so far this year occurred in the City of Chicago.

The average case of undulant fever, Dr. Cross said, is acquired in one of two ways: by drinking raw milk from infected cows or goats or handling infected animals or their infected carcasses. He outlined two methods which are now available for the control of the disease. One is the pasteurization of all milk to be consumed and the other is the elimination of the disease from animals.

"As a safeguard against undulant fever, every consumer of dairy products in both urban and rural areas, should demand only those made from pasteurized milk," Dr. Cross said. For the sake of community health, he urged all farmers to have their animals tested for evidence of this disease.

New Position for Dr. Herbolsheimer.—Dr. Roland R. Cross, director of the state department of public health, on July 7 announced the appointment of Dr. Henrietta Herbolsheimer as medical administrative assistant to the director.

A graduate of the University of Chicago School of Medicine, Dr. Herbolsheimer has been a member of the staff of the department for seven years, serving as chief of the division of maternal and child health and, more recently, as chief of the division of hospital construction and services. From September 1947, to May 30, 1948, she was on leave of absence attending Johns Hopkins University in Baltimore, Maryland, where she received the master's degree in public health. Dr. Herbolsheimer's work at Johns Hopkins included special training in hospital administration.

George K. Hendrix has been appointed chief of the division of hospital construction and services, succeeding Dr. Herbolsheimer. A native of Hancock county, Illinois, Hendrix attended Carthage College and the University of Iowa, where he received the bachelor of science degree in civil engineering. His graduate training in the field of public health engineering was taken at the University of Michigan. Hendrix became associated with the state department of public health in July 1937, first in the division of sanitary engineering and later in the division of hospital construction and services. He also served for three years in the Sanitary Corps of the U.S. Army, where he attained the rank of captain.

Mortality in Illinois.—While birth registrations in Illinois during the first two months of 1948 were well below the level established in corresponding months of last year, mortality for the period increased slightly, according to vital statistics reports released recently by Dr. Roland R. Cross, state director of public health. Births for the 1948 period totaled 27,260 as against 28,087 in the first two months of 1947; and deaths stood at 15,736 in the 1948 period as compared with 15,341 in the corresponding months of last year.

A sharp upward trend marked the mortality rate from heart disease, which accounted for 6,114 deaths in the 1948 period as compared with 5,807 in the first two months of last year, an increase of more than 150 per month.

Dr. Cross pointed out, however, that practically all of this increase was due to deaths among old people. About 65 per cent of all deaths due to heart disease were among persons over 65 years of age, he said.

Deaths from two other degenerative diseases — cancer and diabetes — also rose slightly during the two-month period of 1948. Cancer was responsible for 2,147 fatalities, and diabetes for 483.

The measles epidemic, which reached its peak during February, caused 37 deaths during the first two months of this year. "As usual," Dr. Cross said, "the heaviest toll was among infants and young children." The report shows that 21 of the 37 deaths from measles occurred among children under five years of age. During the comparable months of last year four deaths from measles were reported in Illinois.

The most encouraging feature of the vital statistics report was the reduction in infant mortality. Only 824 infant deaths were reported during the first two months of this year, as against 1,033 in the corresponding period of 1947.

"FOR THE COMMON GOOD"

Lectures Arranged Through the Educational Committee; Charles P. Blair, Monmouth, Chairman:

Adrian D. M. Kraus, Chicago, Fort Dearborn P.T.A., in Chicago, October 13 on "How the Parents of the School Can Make Our Health Program More Effective by Encouraging Protection Through Immunization."

W. W. Bolton, associate director, Bureau of Health Education, American Medical Association, Chicago, Goethe School P.T.A., October 14, on "The Modern Child's Health Opportunities."

Mary G. Schroeder, Chicago, Norwegian Woman's Club in Chicago, November, "Growing Old Gracefully."

Joseph Bertucci, Chicago, Lafayette School P.T.A. in Chicago, November 9, on "Children's Ailments."

Lectures Arranged Through the Scientific Service Committee; Robert S. Berghoff, Chicago, Chairman:

C. Edward Stepan, Chicago, Kankakee County Medical Society in Kankakee, September 10, on "Rheumatic Fever: The Possible Causes and Prevention."

Stuart Broadwell Jr., Springfield, Logan County Medical Society in Lincoln, September 16, on "Hoarseness."

Norbert C. Barwasser, Moline, McDonough County Medical Society, Macomb, September 24, on "Diagnosis and Treatment of Common Skin Diseases."

Conference Arranged through the Postgraduate Education Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman:

The Council of the Illinois State Medical Society has authorized for the second time the holding of twelve post graduate conferences in the Councilor Districts of the state: The Seventh Councilor District has requested the first conference, September 16, in Centralia, with the Marion County Medical Society acting as host. The session will open with a luncheon at the Pittenger Hotel after which the following program will be presented:

Dr. Israel Davidsohn, Chicago, Clinical Applications of the Rh Factor.

Dr. Hugo R. Rony, Chicago, Hormone Preparations and Their Uses.

Dr. Warren Cole, Chicago, Surgical Lesions of the Stomach.

Dr. Lester D. Odell, Chicago, Cesarean Section.

Dr. Noel Shaw, Evanston, Feeding Problems in Infants; Allergic Conditions in Children, and Treatment of Congenital Syphilis in Penicillin.

A round table discussion will conclude the afternoon program. In the evening, following a dinner, Dr. Robert E. Britt, St. Louis, will present "Psychosomatic Medicine."

Dr. Harry E. Ryan, president of the Marion County Medical Society, will preside at the Conference. Dr. Max Hirschfelder is secretary of the society and Dr. Charles H. Hulick, Shelbyville, Councilor for the Seventh District.

Deaths

Jewell Lee Bass, Carbondale, who graduated at the University of Illinois College of Medicine in 1931, died January 11, aged 45, of hepatic cirrhosis.

Eugene D. Bergeron, Kankakee, who graduated at Chicago Medical College in 1881, died February 11, aged 88, of coronary heart disease and cerebral hemorrhage.

Walter William Boyne, East St. Louis, who graduated at St. Louis University School of Medicine in 1913, died June 23, aged 58, following an extended illness. He was formerly coroner of St. Clair County.

William Farmer Briney, Chicago, who graduated at Bennett Medical College in 1897, died February 14, aged 78, of cardiovascular renal disease.

D. Fletcher Coffey, Pana, who graduated at the Hahnemann Medical College and Hospital in 1902, died suddenly, June 12, aged 72, of a heart attack. He had practiced medicine for 46 years.

Herbert Clinton Eastman, Galesburg, who graduated at Northwestern University Medical School in 1921, died in his home, June 9, aged 60. He had practiced medicine as an eye, ear, nose and throat specialist for 25 years.

Warner Leaming Eddy, Milan, who graduated at Rush Medical College in 1892, died February 9, aged 78, of coronary occlusion. Was a past president of Rock Island County Medical Society; served as mayor, member of the village council and board of health.

William Walden Gibbs, Chicago, who graduated at Indiana University School of Medicine in 1917, died February 15, aged 57; for many years affiliated with Provident Hospital, where he died.

GEORGE WILLIAM GINDELE, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1910, died June 13, aged 75. He was associated with the Chicago Health Department for 20 years.

HENRY HOFMAN, Chicago, who graduated at Northwestern University Medical School in 1910, died February 14, aged 62, of cerebral hemorrhage. He had been a member and past president of the staff of St. Bernard's Hospital.

LAWRENCE FRANCIS ISENHART, Mt. Carroll, who graduated at the University of Illinois College of Medicine in 1927, died June 11, aged 49, of a heart attack.

GEORGE KLUMPNER, Ottawa, who graduated at Loyola University School of Medicine in 1921, died suddenly, June 1, aged 55, of a heart attack. He had practiced medicine in Ottawa for 25 years.

SAMUEL JOHNSTON MCNEILL, Chicago, who graduated at Rush Medical College in 1902, died February 16, aged 73, of cerebral hemorrhage.

ARTHUR N. MACKEY, Chicago, who graduated at the Medical College of Indiana in 1892, died June 6, aged 80. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

CLARK R. WILLIAM MAGILL, Oak Park, who graduated at the University of Illinois College of Medicine in 1924, died in an automobile accident, June 30. He had served as a major in the medical corps in World War II. He was 50 years of age.

HARRY OTTEN, Springfield, who graduated at Rush Medical College in 1912, died February 18, aged 65, of coronary disease and fracture of the pelvis as the result of a fall on the ice. He was formerly vice president of the Illinois State Medical Society, past president and vice president of the Sangamon County Medical Society and served as a trustee of the Springfield Medical Library Association.

THEODORE SCHOON, Forreston, who graduated at Loyola University School of Medicine in 1918, died in a Rochester, Minn. clinic, June 8, aged 52. He had practiced medicine in Forreston almost 30 years.

WILLIAM E. SMITH, Grand Ridge, who graduated at Rush Medical College in 1904, died June 21, aged 70, following a heart attack. He had practiced medicine in Grand Ridge about 40 years.

HERBERT F. SPIERLING, Chicago, who graduated at Northwestern University Medical School in 1925, died July 3, aged 53.

HENRY DANFORD STEELE, Princeton, who graduated at Northwestern University Medical School in 1892, died March 3 at the Good Samaritan Hospital, Phoenix, Ariz., of a myocardial infraction. He was 79.

JACOB L. URHEIM, retired, Chicago, who graduated at Bennett Medical College of Eclectic Medicine and Surgery in 1891, died June 16, aged 93. He had practiced medicine on Chicago's west side for 54 years.

CAMILLO EUGENE VOLINI, Chicago, who graduated at Loyola University School of Medicine in 1933, died June 22, three weeks after he suffered a heart attack, aged 40. He was superintendent of clinics at the Chicago Municipal Tuberculosis Sanitarium.

LOUIS JEROME WEISHEW, Oswego, who graduated at Chicago College of Medicine and Surgery in 1912, died of a heart attack, July 1, aged 57.

SCHERING SPONSORS SCIENTIFIC FILM

The first of a series of scientific motion picture films on various phases of endocrinology was recently released by Schering Corporation of Bloomfield, N. J. The subject of the Schering film is, "The Physiology of Normal Menstruation." Completely animated in color and available with or without sound, the film presents the currently held theories concerning the phenomenon of menstruation.

The script of "The Physiology of Normal Menstruation" was written by Dr. Somers Sturgis, Associate Surgeon at the Massachusetts General Hospital and Chief of the Vincent Memorial Hospital Laboratory; and Dr. John Rock, Clinical Professor of gynecology at Harvard Medical School and Director of Fertility, Endocrine and Rhythm Clinics at the Free Hospital for Women, Brookline, Massachusetts. The technical advice and guidance of many other well known endocrinologists were obtained on many aspects of the script. The film was produced by Sturgis-Grant Productions with the sound narration by Mr. Eugene O'Neil, Jr. of Princeton University.

A preview of the film before the Endocrine Society of Philadelphia brought high acclaim for the excellent manner in which the film clarified the subject. Under the personal supervision of Drs. Rock and Sturgis, "The Physiology of Normal Menstruation" was shown at the American Medical Convention in Chicago.

The film was produced by Schering for medical schools and various medical societies. It may be obtained free of charge for showing before interested groups by writing to the Medical Service Department of Schering at Bloomfield, New Jersey.

ENGLISH DIET INCREASES BIRTH RATE, JOURNAL REPORT SAYS

Severe food restrictions and rationing have played an important part in improving the health of England and increasing her birth rate, two Boston investigators say in an article appearing in the May 8 issue of The Journal of the American Medical Association.

The report, which is on nutritional needs during pregnancy, was written by Bertha S. Burke, M.A., and Harold C. Stuart, M.D., both from the Department of Maternal and Child Health, School of Public Health, Harvard University, Boston.

In their article they state that "under the severe restrictions imposed by war, England appears to have profited considerably with respect to health as a result of her need to utilize all her available food as efficiently as possible," adding that "although the diet has been extremely monotonous, the average nutritional quality of the English diet has been improved."

Speaking of the effect of diet on the English birth rate, the authors add:

"Previous to the war, the diet of the pregnant woman in the lower income brackets in England was poorer than that of the average adult, but during the war special attention was focused on her diet. For the first time in the history of England, special food was made available to all pregnant women in the form of additional milk, eggs, supplementary vitamins and other extra rations when possible."

Studies show, the article says, that there was a sharp drop in the stillbirth rate in England and Wales after the rationing program was instituted, adding that the decrease was greatest in the poorest economic districts, such as Wales, where it amounted to 35 per cent.

The investigators point out that "these conditions occurred at a time when all conditions of life other than nutrition had deteriorated."

The report also reveals the results of studies in other countries, many of which have contributed to the knowledge of the effect of nutrition on pregnancy.

In Holland, for example, it was found that during the "hunger months" of the war and right after, about 50 per cent of the women suffered from amenorrhea (absence or stoppage of menstruation) and were presumably infertile. However, the article states, "this condition disappeared promptly with the return of food."

The study in Holland also disclosed that the birth weights of infants born at full term decreased suddenly during the hunger months and rose almost as abruptly as the country emerged from the severe starvation period.

In the United States, results of studies also show definite relationship of diet to pregnancy and birth.

In a group of 216 cases, studied at the Boston Lying-In Hospital, all of the stillborn infants, all except one of the infants who died in the neonatal (newborn) period, all except one of the premature infants, most of the infants with congenital defects, and all of the infants considered to be "functionally immature" were born to women in the poorest diet group.

In contrast, the study showed that 94 per cent of the infants born to mothers on good or excellent diets during pregnancy were in good or excellent physical condition at birth.

Commenting on this and other studies, the authors say:

"With such strong evidence that good diet during pregnancy lessens the likelihood of complications and contributes to a safer labor and delivery, there would seem to be ample reason for intensive efforts on the part of obstetricians and general practitioners to improve the diets of all pregnant women coming to them for prenatal care.

"The added evidence that women who have excellent or good diets during pregnancy are much more likely to have well-developed, healthy infants, and much less likely to have stillborn or prematurely born infants increases the incentive to improve maternal dietaries."

To insure optimum nutrition during pregnancy, the authors recommend a daily diet consisting of: one quart of milk; at least four ounces of lean meat, including liver once a week; two servings of fruit, plus two oranges or orange juice; at least two cooked or raw vegetables, plus a potato in its skin; at least four slices of whole grain or enriched bread, two tablespoons of butter or fortified margarine; some form of vitamin D to supply 400 to 800 international units, and enough additional foods to supply the desired weight gain.

PREPARE GLOSSARY OF TERMS USED IN ATOMIC ENERGY

To better inform the physician, the Council on Physical Medicine of the American Medical Association has prepared a glossary of terms used in atomic energy and nuclear physics.

The introduction to the pamphlet says that "nuclear physics as it develops will have important consequences to the practicing physician. New types of injury may require treatment, new hazards will require prevention and new methods of treatment, diagnosis, and research will be introduced. In attempting to inform himself about recent discoveries the physician is constantly baffled by the new vocabulary, which contains some words too recent or too technical to be found in older or less specialized dictionaries. The present glossary is intended to be helpful in this respect."

The glossary was adopted by the Council on Physical Medicine of the American Medical Association, assisted by a large number of consultants on roentgen rays and radium and on the medical aspects of atomic energy.

The glossary explains such terms as atom, atomic number, chain reaction, cosmic rays, cyclotron, element, energy, isotron, isotopes, neutron, radioactivity, radioactive chain, radon, plutonium, uranium, volt and wavelength.

The pamphlet also contains symbols used in writing nuclear reactions.

TUBERCULOSIS CONTROL IN INDUSTRY

Tuberculosis control among employees of The Eastman Kodak Company was begun in 1921 with a roentgenographic survey of the chests. In 1923 it was enlarged to include periodic roentgenograms of the chests of all employees as well as the examination of applicants.

In a report made by Dr. William A. Sawyer in 1939, this work was reviewed for the years 1923 to 1937. At that time the incidence of active disease per thousand employees in three-year periods was shown to have dropped from 2.08 in the period 1923 to 1925 to 0.47 in the period 1935 to 1937. During the war years the labor turnover was unusually high, and therefore the incidence cannot accurately be determined. In only 18 persons did active pulmonary tuberculosis develop over a period of five years, among employees increasing in number from 6,000 in 1941 to 10,000 in 1945. Though the increment was only 4,000, the number of applicants employed for varying periods of time during the period 1941 to 1945 totaled 20,500. Active pulmonary tuberculosis appeared at all age levels. The ratio of the number of cases in each decade to the percentage in each ten-year group employed is nearly uniform throughout.

Those in the higher age groups might even be regarded as more vulnerable to tuberculosis, since they have been subject to a "weeding out" process over the years. Those who survive have the same attack rate as those aged 20 to 40 years, usually considered to be more vulnerable.

At the present time two per cent of all employees have roentgenograms of the chest classified as indicating pulmonary tuberculosis, minimal inactive.

Following the preemployment roentgenogram, routine 14 by 17 inch roentgenograms are retaken as follows:

Age When Employed	*Years Between Routine Roentgenograms*
5 years thereafter	
25-34 years	2, 3 and 5
To 25 years	1, 3 and 5
35 to retirement	3 and 5 and every 5 years thereafter

5 and every....3 and2n

In addition roentgenograms are taken after prolonged absence for any reason, and in the presence of suggestive symptoms.

The majority of the group (11 cases) in which active pulmonary tuberculosis developed later had roentgenograms of the chest indicating abnormalities at the time of employment. In three cases this was an "apical cap," a term used to describe a crescentic, homogenous soft tissue density, over the dome of the apex of the lung.

Stage of Disease When Discovered to be Active

The one case of far advanced disease discovered contradicts an oft repeated rule, namely, that a person with a normal roentgenogram of the chest at age 40 will never have active pulmonary tuberculosis. This woman, aged 56 at the time of employment, had what was considered to be an inactive infraclavicular lesion. One year after employment she was taken acutely ill with what appeared to be virus pneumonia. Three weeks after onset of the disease her sputum contained tubercle bacilli, and in six weeks a 5 cm. cavity developed.

Signs and Symptoms Accompanying Active Disease

Each person was carefully interviewed for a history of his disease in retrospect. In only one could the symptoms elicited be said to have been more than suggestive: an acute respiratory infection with a small hemoptysis.

There were two cases in which pneumonia was the sidered to be of the virus type early in its course.

Location and Spread of Lesions

presenting symptom. In each instance it was con-

In recent years, the importance and gravity of an infraclavicular lesion have been emphasized. Earlier it was held generally that in adults all pulmonary tuberculosis began in the apex, producing symptoms and signs of "consumption" as the lesion extended downward below the clavicle. In this small series, apparently inactive lesions in both apex and infraclavicular regions have been the starting point of active disease.

Years Between Employment and Tuberculous Activity

In mass surveys the question of frequency of reexamination arises. Do roentgenograms of the chest which are negative and "clinically not significant" for one, three or five years imply lifelong freedom from active disease? The answer is indubitably no; repeated roentgenograms at regular intervals, after prolonged absences and in the presence of suggestive symptoms are indicated. The four persons in whom active pulmonary tuberculosis developed upward of 10 years after their employment had had minimal inactive infection throughout that period; the lesions had appeared hard, and serial roentgenograms had shown no change.

Duration of Treatment

It has long been known that the time required to arrest active pulmonary tuberculosis is closely correlated with the stage of disease when treatment is instituted. Six to 18 months is usually required to arrest minimal lesions. In only two cases of this series was this time exceeded.

All of the minimal infections were treated by rest alone. Pneumothorax was successful in controlling moderately advanced disease, and the person thus affected was returned to work after 18 months, therapeutic pneumothorax being maintained.

Tuberculosis Control in Industry, Charles R. Allison, M.D., Occupational Medicine, September, 1946.

The tuberculous patient who has not learned the practical facts of life concerning tuberculosis, who has not found a job and a way of living which are compatible with his individual case, can hardly look forward to a successful recovery and a useful life. Paul R. Hawley, M.D., Bull. Am. College Surgeons, Sept., 1947.



FROM THIS DAY ON . . .

THE DIET OF AN INFANT soon after birth becomes the prime problem in getting the child off to a good start. Variations in the diet must often be based on tolerance, with little attention to vitamin values. Early avitaminosis may develop during periods of dietary adjustment.

Five cc. (approximately one average teaspoonful) of 'Homicebrin' (Homogenized Vitamins A, B_1, B_2, C, and D, Lilly) contain up to two times the daily allowance of the essential vitamins A, B_1, B_2, C, and D.

This homogenized preparation is pleasantly flavored and is completely free from a fish-oil taste or odor.

'Homicebrin' is available in bottles of 60 cc. and 120 cc. at retail drug stores everywhere.

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why this is the ideal phenobarbital preparation for children . . .

ESKAPHEN B ELIXIR

1 Its fluid form makes it easy to take.

2 Its good taste makes it pleasant to take.

3 Its calming action is supplemented by the tone-restoring effect of thiamine.

And this is important, too: Parents who "know all about phenobarbital"—and might be upset at the idea of giving it to their children—won't know you are prescribing phenobarbital when you write ESKAPHEN B ELIXIR.

Smith, Kline & French Laboratories, Philadelphia

ESKAPHEN B ELIXIR

Each teaspoonful (5 cc.) contains: phenobarbital 1/4 gr. and thiamine 5 mg.

The delightfully palatable combination of phenobarbital and thiamine

There are so many kinds of Eczema . . . **TAR IS THE MASTER REMEDY**

Tarbonis is of outstanding value in

Eczema
Psoriasis
Ringworm
Occupational Dermatitis
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In 2¼ oz., 8 oz., 1 lb. and 6 lb. jars.

•

When infection supervenes, SUL-TARBONIS combines the bactericidol properties of sulfothiazole (five per cent) with the virtues of Tarbonis.

. . . AND THERE ARE so many tar preparations! Crude and refined, white and black, and in many different vehicles. In the hands of many leading dermatologists, pediatricians, and general practitioners, Tarbonis — because of its distinctive advantages — is the preferred tar preparation in the management of eczema.

In most instances, eczema requires intense and prolonged treatment. Tarbonis, presenting a 5 per cent alcoholic extract of carefully selected crude tars together with lanolin and menthol in a vanishing-type cream, is completely nonirritant. It is safely applied as often as desired, every two hours if indicated, for as long as needed, without leading to superimposed irritation or furunculosis.

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THOUGH *Higher in Choline Content*



Presenting the equivalent of 12.5 per cent choline base or 14.4 per cent choline chloride, Syrup Choline Bicarbonate-C.S.C., an entirely new choline preparation for therapeutic use, permits effective dosage in the treatment of fatty infiltration of the liver and portal cirrhosis. Because the bicarbonate salt of choline is unusually well tolerated, administration in the recommended quantity—6 to 7 Gm. daily—rarely produces gastric distress or nausea. Choline therapy, combined with a dietary high in carbohydrate, complete protein and B complex vitamins, may reverse the process of lipid deposition in the liver, and forestall or prevent the otherwise inevitable final stage of cirrhosis. Syrup Choline Bicarbonate-C.S.C., available on prescription at all pharmacies, is the most economical choline preparation on the market today.

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WHAT IS BILIOUSNESS?

"Biliousness" is today regarded as an unscientific term but it is nonetheless real and distressing to the patient who complains of it. It is used to imply a variety of such symptoms as eructations, pyrosis, bloated feeling, epigastric or abdominal distress—particularly after meals. Such symptoms may, of course, result from a variety of causes but mild biliary tract disease is a very common etiologic factor.

For these cases DEHYDROCHOLIC ACID *ARMOUR* often affords great relief. This preparation induces a profuse outflow of thin, watery bile of very low viscosity. It overcomes biliary stasis, carries away toxins, and helps prevent ascending infection. It is of value in the medical management of chronic gall-bladder cases, with or without stones, provided there is no actual obstruction. It is indicated also in liver poisoning, in cirrhosis, and in chronic passive congestion. It is contraindicated when the common bile duct is obstructed.

Supplied in 3¾ grain tablets—bottles of 50, 100, 500. Dasage: One ta 3 tablets t.i.d with meals. Literature an request.

Dehydrocholic Acid

Have confidence in the preparatian yau prescribe — specify "ARMOUR"

ARMOUR *Laboratories*

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Amazing discrepancies!

"Amazing discrepancies . . . usually exist between the food the patient *eats* and that which the surgeon [or physician] *thinks* the patient eats."[1]

Among medical and surgical patients, it is particularly important to eliminate any discrepancy between vitamin needs and vitamin intake by reinforcing a good diet with multivitamins in therapeutic potencies. "A good capsule of this type is Upjohn's Zymacaps."[2]

1. Canada M. A. J. 54:283 (Mar.) 1946.
2. J. South Carolina M. A. 44:17 (Jan.) 1948.

Each Zymacap* provides:

Vitamin A	12,500 U. S. P. units
Vitamin D	1,000 U. S. P. units
Thiamine Hydrochloride	5 mg.
Riboflavin	5 mg.
Pyridoxine Hydrochloride	2 mg.
Calcium Pantothenate	10 mg.
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PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER



ELECTROTHERAPY IN GENERAL PRACTICE

L. D. Bailey, C.B., M.D., M.R.C.S., L.R.C.P., D.P.H. In THE PRACTITIONER, 1945:158:197, March 1947.

Electrotherapy in private practice, or indeed in any practice, should be undertaken only by those who have a clear understanding of the physical properties of the agents they are employing and of the physiological effects of these agents on the living tissues of the human body. To employ electrotherapy merely as a means of increasing practice or income without any idea of its beneficial or harmful effects is not only unscientific, but may have disastrous effects on the patient and bring this undoubtedly valuable form of treatment into disrepute. On the other hand, electrotherapy, at present in its infancy, should, with ample opportunity for research, develop into one of the most powerful adjuncts to medicine.

What then are the physical agents with which we have to deal in electrotherapy? They may be summed up into four categories:—(1) Electrical currents—direct, alternating and oscillating; (2) heat; (3) light; (4) certain wave lengths in the electro-magnetic field outside the visible spectrum.

The Galvanic Current

The constant current, commonly known as the galvanic current, has several uses. In the first place it must be understood that this current traverses the tissues by regular "ionic" movement of salts in solution in the body, and that during its passage it meets with a certain amount of resistance, the most resistant tissue in this case being the skin.

All of these ions are driven into the tissues either directly or in combination in 1 or 2 per cent. solution. As only a certain number of ions can be introduced in any specified time, according to the weight of the ion, any stronger solution is of no avail.

Histamine is most conveniently administered by the application of histamine jelly or ointment (sometimes known under the proprietory name of "imadyl"). This can be lightly rubbed into the skin, preferably with cotton-wool or a rubber glove to protect the operator, and over this are placed the usual sixteen layers of lint soaked in normal saline, and the positive electrode. The cathode soaked in 2 per cent. sodium salicylate may then be placed over the chief site of referred pain and a current of 3, 4 or 5 m.a. for five to ten minutes passed daily for a week, or three times weekly for two weeks, and the result noted. If there is no improvement in the fibrositic condition noticed after six treatments, it is useless to continue with this type of medication. Besides fibrositis and neuritis other

(*Continued on page 42*)



for the convalescent

hemoglobin build-up

PLUS nutritional support

Slow regeneration of blood is one of the most frequent—and often unappreciated—reasons for delayed and inadequate convalescence after both acute and prolonged illnesses as well as after surgery. This is not surprising since even in otherwise healthy individuals a drop of only 10 or 15 percent in the hemoglobin level commonly produces definite asthenia and easy fatigability. Cytora is of particular value for convalescents because it provides important factors necessary for rebuilding blood plus other dietary essentials; each Cytora tablet supplies liberal quantities of iron, folic acid, liver concentrate, vitamin C and five B-complex factors. The pharmaceutical skill exercised in compounding Cytora tablets assures optimal absorption of the active ingredients and minimizes gastric disturbances. Cytora also eliminates a senseless multiplication of medications for the convalescent who might otherwise require several individual medicinal agents to rebuild his blood and improve his nutrition. Cytora is available in bottles of 100, 250, and 1000 tablets.

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DAILY DOSE (6 TABLETS) PROVIDES:	
Ferraus Sulfate	600.0 mg
Folic Acid	4.5 mg
Liver Cancentrate	900.0 mg
Vitamin C	150.0 mg
Vitamin B_1	6.0 mg
Vitamin B_2	6.0 mg
Vitamin B_6	3.0 mg
Niacinamide	30.0 mg
Calcium Pantathenate	6.0 mg

plus ather factors naturally present in liver cancentrate

Available in bottles af 100, 250 and 1000 —

conditions which will greatly benefit from histamine ionization are vascular deficiencies, such as Raynaud's disease, acrocyanosis, and early cases of rteriosclerosis.

Alternating Currents

Alternating currents may be of high or low frequency, that is to say a current as used for medical purposes may alter its direction of flow from 50 to 50,000,000 times per second. Dealing first with low frequency alternations the currents chiefly employed are the sinusoidal current and the faradic current. The sinusoidal current in most modern apparatus conforms to the periodicity of the main current supply suitably reduced in voltage for the apparatus employed. It stimulates both muscle and skin nerve endings and can therefore be used to produce either muscle contractions or skin stimulation, but owing to its somewhat painful effect when used as sufficient strength to cause muscle contraction, it is not as a rule used for this purpose, and is definitely inferior in action to the faradic current. Its chief use, like the interrupted galvanic current, is for ciculatory disturbances, such as general impoverished circulation in the extremities, Raynaud's and Bazin's disease.

The Faradic Current

The faradic current has three principal uses:—(a) Muscle stimulation; (b) sensory nerve stimulation; (c) electro-diagnosis.

The Oscillating or High Frequency Current

Oscillating currents, or currents of high frequency which alter their direction of flow from anything between 5,000 to 1,000,000 in long wave diathermy and to 50,000,000 times per second in short wave therapy, owe their therapeutic effects to the generation of heat in the tissues. The practitioner who is going to use these currents in private practice must be aware of a few fundamental principles.

Although the patient appreciates the warmth of the current in the skin it is a poor criterion

(*Continued on page* 44)

NEO-CULTOL*
for the treatment of constipation
Natural Corrective
Non-Habit Forming
L. acidophilus in refined mineral oil jelly, chocolate flavored — provides natural, physiologic approach to correction of stasis. Supplies lactobacilli, predominant flora of the normal intestine . . . gently lubricates. Restores normal function without griping, flatulence, diarrheic movements. Melting point adjusted to prevent leakage. Jars containing 6 oz.
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Laboratory studies on sperm-immobilizing power and clinical studies on occlusive action and safety establish that "RAMSES" Vaginal Jelly affords the optimum protection that a jelly alone can provide. For example.*

- It will immobilize sperm in the fastest time recognizable under the Brown and Gamble method.
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Active Ingredients: Dodecaethyleneglycol Monolaurate 5%; Boric Acid 1%; Alcohol 5%.

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Physical Medicine (Continued)

of the amount of heat produced in the deeper tissues, such as fat and bone, and for this reason deep-seated burns may occur which are not immediately evident. This is, doubtless, the chief danger of diathermy and short wave applications. Other untoward effects may be dizziness if the treatment is adminstered near the brain, and syncope if a large area of the body is being treated. Although these treatments may be given with good effect to the whole body for the amelioration of symptoms, such as headache, flushing and vertigo in cases of high blood pressure, they would be administered very cautiously in patients suffering from abnormally low blood pressures. The application of warmth in cases of rheumatism is too well known to need any emphasis here, but the deep-heating effects of these currents render them especially efficacious in chronic rheumatoid arthritis and early osteoarthritis.

Irradiation

Heat, light, infra-red and ultra-violet irradiations may be considered together in the first instance as they have all the physical properties in common. That is to say, these rays, whether derived from the sun or from artificial sources are either (a) absorbed, (b) transmitted, (c) reflected, or (d) refracted, according to their wave length.

MANIPULATION IN GENERAL PRACTICE

A. G. Timbrell Fisher, M.C., M.B., Ch.B., F.R.C.S. In THE PRACTITIONER, 945:158:209, March 1947.

Treatment by manipulation of many chronic disabilities of the joints and spine, and of the locomotor system generally, is often of the greatest value in carefully selected cases. The time-lag in the recognition of its value has been due to a number of factors, one of the principal of which has been the bad results often attending manipulations by unqualified practitioners and which far outweigh their occasional successes. The clinical and pathological training that a qualified medical man receives should largely eliminate this objection. Another factor militating against the recognition of manipulative treatment has been the view that, owing to the acute reaction in the joint which is alleged to

(*Continued on page* 46)

about the **LARYNX,** the **PHARYNX...** and **CIGARETTES**

Here is the simple reason why many leading nose and throat specialists suggest "Change to Philip Morris."*

The sensitive tissues of the upper respiratory tract are often affected adversely by the irritants in the smoke of ordinary cigarettes.

Philip Morris, on the other hand, are specifically processed to *minimize* such irritants . . . the only one of all leading cigarettes to offer this advantage.

Why not give your patients the benefit of this proved** superiority . . . why not suggest Philip Morris. Many leading doctors make it a point to say to their patients who smoke . . . *"Change to Philip Morris Cigarettes."*

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc.
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ARE YOU A PIPE SMOKER? . . . We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

*Completely documented evidence on file.

**Reprints on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

follow manipulation, more satisfactory results can be obtained by gradual methods, such as re-educational exercises, supplemented by physical treatment in such forms as heat, massage and electricity. Such methods are often of great value in minor cases of post-traumatic or rheumatic adhesions, or when used either as a preliminary or sequel to manipulation in more severe types of crippling. Exercises and physical methods have, however, their limitations; the practice of continuing with them indefinitely when progress is not being made and when residual stiffness might be speedily rectified by manipulation is not in the patient's best interests and is contrary to common sense. When the necessary knowledge and skill have been acquired, and with careful selection of cases, post-manipulative reaction in a joint is a rare phenomenon and this bogey should not therefore be raised as an argument against manipulation when the ideal time for this has arrived.

As has already been noted, but it will bear repitition, the cases of articular or periarticular adhesions that respond best to manipulation are those which have brought about a slight or moderate degree of limitation of movement, associated with pain and/or swelling, and which have failed to respond to ordinary methods of physical treatment. The art of manipulation does not consist solely in moving the joint through its full range of movement, as is sometimes asserted. There is a special technique for every joint and a famous bonesetter was not far wrong when he said "It's the twist that does it."

PHYSIOTHERAPY AND THE ATHLETE

J. E. Lovelock, B.M., M.R.C.P. In THE PRACTITIONER, 945:158:226 March 1947.

In this article physiotherapy is defined as treatment by natural means, as opposed to drugs and surgery. These include rest, movement and massage, heat and cold, light and electricity, and water. An athlete is defined in the original Greek conception as one who takes part in any contest or struggle (C. O. D. 1931 — competitor in physical excercises); it is not interpreted in the narrow sense of a track or field athlete. Competition with its emotional urge and its intellectual control is essential to the conception of an athlete.

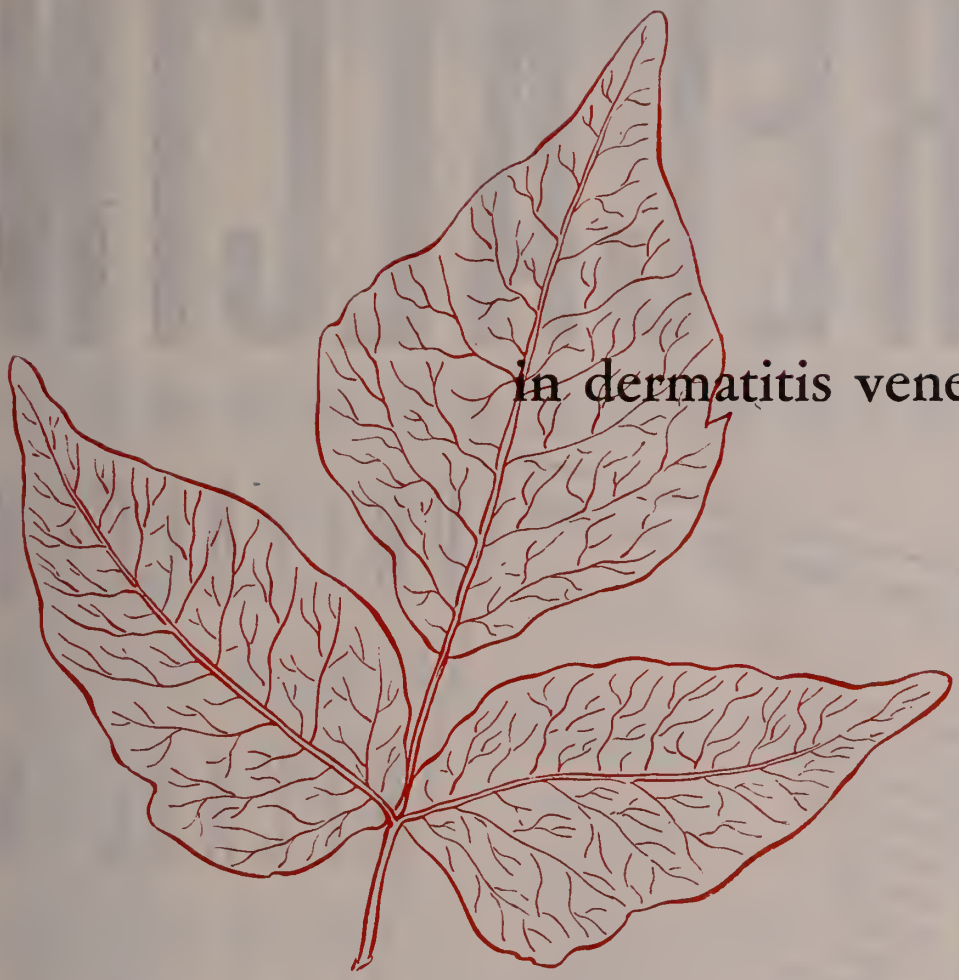
In its broadest sense the subject could be taken to embrace the complete training of a competitor in any sport or game, and should include a dissertation on training as well as on all injuries and diseases. This is of too wide a scope for discussion here, and the practitioner comes in professional contact mainly with those whose training has for one reason or another failed. The more serious of these failures, such as fractures of bones, severe sprains of joints, badly torn muscles or nerves, or cerebral concussion, should pass immediately into specialist hands; but a host of lesser failures remains with the practitioner and is the source of much sick wastage with time lost from competition.

RHEUMATISM AND ARTHRITIS

Committee Report, Philip S. Hench, M.D., F.A.C.P., Chairman. In ANNALS OF INTERNAL MEDICINE Vol. 28 (O.S., Vol. XXXII): 298 February 1948.

Tenosynovitis.—General Treatment. Of the various treatments discussed Frank preferred rest and immobilization in acute cases, roentgen therapy in chronic cases. Roentgen therapy was favored by Zander: in a case with both hips affected the symptoms and calcific deposits disappeared rapidly from the radiated side and remained unchanged on the untreated side. Immobolization in plaster or splints for five to seven days, then physical therapy for one to three weeks cured Cooper's 78 patients. According to Kaplan rapid relief was afforded by procaine.

Fibrositis.—This is the most common form of acute and chronic rheumatism (Slocumb), but the term is "too loosely applied and ill-defined" (Ellman and associates). Because of its variable manifestations "it marches under false banners, assumes numerous disguises, and is known by a variety of aliases" (Swett). *Treatment.*— The value of rest, heat, massage, salicylates and correction of postural defects were again noted. Rest is essential in acute cases. Skilled, heavy massage and "stretching" exercises were recommended. Such measures are effective even in "the fibrositis of old age."



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The itching produced by contact with oleoresins of wild plants such as poison ivy, oak and sumac, as well as the pruritus of other dermatoses, will frequently be relieved by . . .

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PYRIBENZAMINE OINTMENT 2 per cent (petrolatum base). Jars of 50 Gm. and 1 pound.

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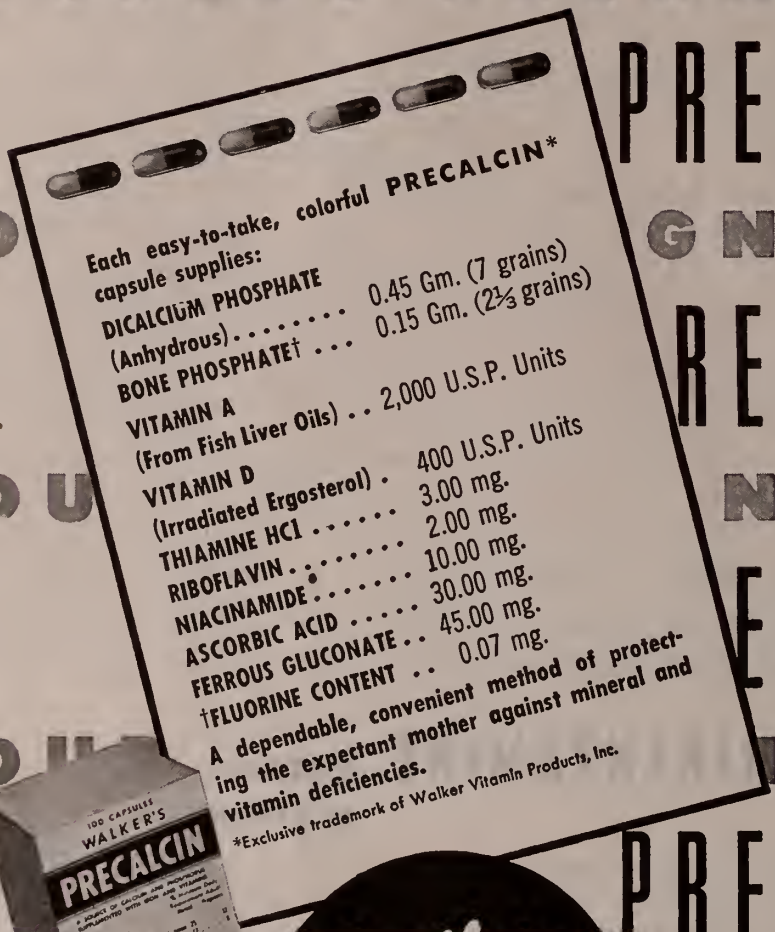
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PYRIBENZAMINE (brand of tripelennamine)—Trade Mark Reg. U.S. Pat. Off.

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DURING PREGNANCY

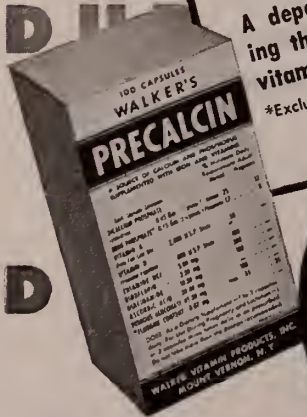


Each easy-to-take, colorful PRECALCIN* capsule supplies:

DICALCIUM PHOSPHATE (Anhydrous)	0.45 Gm. (7 grains)
BONE PHOSPHATE†	0.15 Gm. (2½ grains)
VITAMIN A (From Fish Liver Oils)	2,000 U.S.P. Units
VITAMIN D (Irradiated Ergosterol)	400 U.S.P. Units
THIAMINE HCl	3.00 mg.
RIBOFLAVIN	2.00 mg.
NIACINAMIDE	10.00 mg.
ASCORBIC ACID	30.00 mg.
FERROUS GLUCONATE	45.00 mg.
†FLUORINE CONTENT	0.07 mg.

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Walker
VITAMIN PRODUCTS, INC.
MOUNT VERNON
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WIDE RANGE OF ANTIBACTERIAL ACTIVITY *in* URINARY-TRACT INFECTIONS

Clinical and experimental evidence has established the effectiveness of MANDELAMINE* against a wide range of bacteria, particularly those encountered most frequently in common infections of the urinary tract. Presenting the combined antibacterial properties of two potent agents, mandelic acid and methenamine, in chemical combination, MANDELAMINE has broad therapeutic applicability with remarkably low incidence of toxic reactions.

6 FEATURES OF MANDELAMINE THERAPY

1. No gastric upset
2. No dietary restriction or fluid regulation necessary
3. No accessory acidification required, except when urea-splitting organisms are present
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5. No danger of drug-fastness
6. *Simple oral dosage*—3 or 4 tablets t.i.d.

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Brand of Hexydaline
(Methenamine Mandelate)

SUPPLIED: Enteric-coated tablets of 0.25 Gm. (3¾ grains) each; packages of 120 tablets sanitaped, and bottles of 500 and 1,000.

*MANDELAMINE is the registered trademark of Nepera Chemical Co., Inc., for its brand of Hexydaline.

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BOOK REVIEWS



MEDICO-LEGAL PROBLEMS: Edited by Samuel A. Levinson, M.D., Ph. D., J. B. Lippincott Company, Philadelphia, 1948; Price $5.00.

In the fall of 1945 a Medico-Legal Symposium was presented jointly in Chicago by the Institute of Medicine of Chicago and the Chicago Bar Association. The reactions to this type of arrangements were very encouraging indeed, and it showed the desirability of the two professions, Medicine and Law getting together to discuss the many problems of particular interest to both groups.

The following six subjects were selected for this open forum type of presentation:

1. The Medical Witness in Court; "expert testimony".
2. Artificial Insemination; Medicolegal Implications.
3. The Practice of Pathology and Its Medicolegal Problems.
4. Operations to Produce Sterility; Medicolegal Implications.
5. Trauma and Tumors in Industrial Medicine.
6. Scientific Tests in Evidence; Blood Grouping Tests in Disputed Paternity Cases; Chemical Tests for Intoxication.

For each of these presentations, a medical man started the discussion, giving the medical aspects of the condition under consideration, then a member of the legal profession discussed the legal angles, then a moderator was selected to conduct the question and answer period for each of the subjects.

This method proved most satisfactory, as is related in considerable detail in the book, and the information therein contained is of much interest to members of both the medical and legal professions. These are all practical subjects and of the type which are presented to the medical and legal profession quite often in these times. The book will be of much interest to medical men anywhere, and no doubt will be welcomed likewise by many members of the legal profession throughout the country.

MINOR SURGERY — (Sixth Edition) By Frederick Christopher, B.S., M.D., F.A.C.S., Associate Professor of Surgery at Northwestern University Medical School, Chief Surgeon, Evanston (Illinois) Hospital Sixth edition. 1058 pages, 937 illustrations on 595 figures. Philadelphia & London: W. B. Saunders Company 1948. Price $12.00.

Christopher's "Minor Surgery" has become a standard text through the years of its several editions. The purpose of the book is to reach physicians who will see the majority of minor surgical conditions throughout the country. To meet this need, the author includes pathogenesis, diagnosis and treatment, and the signs and symptoms which will have important prognostic consequences. Material for the book represents the experiences of the author and a condensation from several thousand current surgical writings. Practically every conceivable minor surgical condition is touched upon covering all regions of the body.

The sixth edition has been revised and rewritten in many sections. Newer drugs and antibiotics are discussed. World War II experiences are included where practical. "Minor Surgery" has earned its place through its clear description, application of technique, elimination of controversial material, and inclusion of principles which the physician can use from day to day.

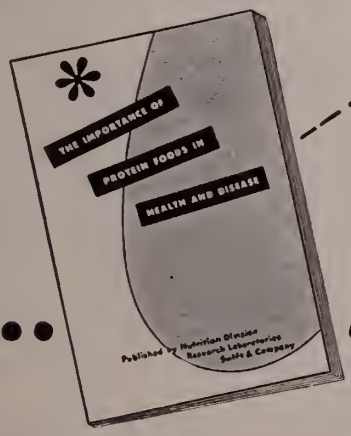
J. W. F.

BERGEY'S MANUAL OF DETERMINATIVE BACTERIOLOGY. Edited by Robert S. Breed, New York State Experiment Station (Cornell University), Geneva, New York; E. G. D. Murray, McGill University, Mon-

(*Continued on page* 52)

EFFECTS OF INFECTIOUS DISEASES AND TRAUMA ON BODY PROTEIN

There are two large groups of disorders which produce generalized protein breakdown: *infections*, acute and chronic, and *trauma*. Infections usually produce fever. A rise in temperature of one degree Fahrenheit means a seven to ten per cent rise in metabolic rate. In addition, bacterial toxins may cause protein breakdown by affecting the cells directly. For these reasons, loss of weight is an outstanding feature of infectious diseases. Diet, especially during convalescence, is therefore high in calories and in the *proportions of protein*. Certain types of injury produce an intense protein *breakdown* which may last for several weeks. The negative nitrogen balance which follows injury is difficult to counteract. *Extremely high protein intakes* are needed to minimize the loss of body tissue.*



""The Importance of Protein Foods in Health and Disease"—new physicians' handbook on protein-feeding. Prepared by a physician, in conjunction with the Nutrition Division of Swift & Company, this booklet will be sent you on request. Simply fill out the coupon.*



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Book Reviews (Continued)

treal, Province Quebec, Canada; and A. Parker Hitchens, University of Pennsylvania, Philadelphia, Pennsylvania; Assisted by sixty contributors. Sixth Edition. The Williams and Wilkins Company, Baltimore. 1948. 1529 pages. $15.00.

This is the sixth edition of this standard reference work. It was first published in 1923 and is now regarded as a classic. It is of course intended for use as a key to classify bacteria into families, tribes and genera. It has been completely revised and reset in this new edition in double column format allowing more material per page. Over 300 new species have been added. The filterable viruses are completely covered. A source and habitat index has been added.

This book represents the summation of all that is known about bacteriological classification. It should be useful to teachers and research workers in bacteriology.

THE RH FACTOR IN THE CLINIC AND THE LABORATORY. Edited by Joseph M. Hill, M.D. and William Dameshek, M.D. Special Issue No. 2 of *Blood, the Journal of Hematology*. 1948. Grune and Stratton, 381 4th Avenue, New York City. 192 pages. $4.25.

This book consists of a series of papers given by hematologists at the International Hematology and Rh Conference held in November, 1946. It is presented as a special issue of *Blood — The Journal of Hematology*. The contributing hematologists are recognized leaders in their fields and their coverage of the highly complicated subject is quite complete. The controversial matters of nomenclature; the Fisher-Race theory of three gene loci vs. the Wiener theory of multiple alleles; blocking antibodies vs. cryptagglutinoids and other matters of present day importance are taken up in a stimulating manner.

This small book is an interesting addition to the large amount of highly technical literature which has appeared on the Rh factor since 1940.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

DIAGNOSIS IN GYNAECOLOGY: (A Classification of Gynaecological Diseases Based on Aetiology and the Clinical Logic for Diagnosis) By James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Director of Gyneacology and Obstetrics, Columbus Hospital; Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York;

(*Continued on page* 56)



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Spencer, Inc., New Haven 7, Conn.
Spencer Support Shop, Chicago 2

CLASSIFIED

Classified Advertisements 60

FOODS

American Diet Service, Detroit 26, Mich.
Borden Company, 350 Madison Ave., New York 28
Campbell Cereal Co., Minneapolis, Minn.
Coca Cola, Atlanta, Ga. 55
Knox Gelatin Laboratories, Johnston, N. Y.
Libby, McNeil & Libby, Chicago 9
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover
National Dairy Products, New York, N. Y.
Nestle's Milk Products, Inc., 155 E. 44th St., New York 17
Swift & Co., Chicago 51
Wander Company, 360 N. Michigan Ave., Chicago

FINANCIAL AND INSURANCE

Medical Protective Co., Fort Wayne, Ind. 18
Physician Casualty Co., Omaha, Neb. 52

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 21
Ames Co., Inc., Elkhart, Ind.
Arlington Chemical Co., Yonkers 1, N. Y. 10, 42
Armour Laboratories, Chicago 9, Ill. 38
Ayerst, McKenna & Harrison Ltd., New York 16 27
Baybank Pharmaceuticals, New York 4
Borcherdt Malt Extract Co., Chicago 12, Ill. 60
Bristol Laboratories, Inc., Syracuse 1, N. Y. 15
Bristol-Meyers Co., New York
Ciba Company, Summit, N. J. 4, 47
Commercial Solvents Corp., Terre Haute, Ind. 8, 37
Crookes Laboratories, Inc., 305 E. 45th St., N. Y.
Doho Chemical Corp., New York 13, N. Y.
Durex Products, New York
Endo Products, Inc., Richmond Hill 18, N. Y.
Otis E. Glidden & Co., Evanston
Gold Pharmacal Co., New York 59
Hoffman-LaRoche, Inc., Nutley, N. J. 6
Holland-Rantos Co., Inc., 551 Fifth Ave., New York
Hoosier Pharmacal Co., Indianapolis, Ind.
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 44
Interchemical Corp., Union, New Jersey 30
International Pharmaceutical Corp., Boston 16
International Vitamin Corp., 50 E. 42nd St., New York City
Irwin, Neisler & Co., Decatur, Ill.
Lanteen Medical Laboratories, Chicago 10 14
Thos. Leeming Co., 155 E. 44th St., New York 17
Lily, Eli & Co., Indianapolis, Ind. 31, 32, 33
Maltbie Chemical Co., Newark, N. J.
S. E. Massengill Co., Bristol, Tenn. 16
McNeil Laboratories, Inc., Philadelphia, Pa.
Merck & Co., Rahway, N. J. 29
Morris, Philip & Co., 119 Fifth Ave., New York 45
Nepera Chemical, Yonkers, N. Y. 49
Num Specialty Co., Pittsburgh, Pa. 58
Parke, Davis & Co., Detroit, Mich. 19
Plastishield, Inc., Minneapolis 2, Minn.
Rare Chemicals, Inc., Flemington, N. J.
Reed & Carnrick, Jersey City 6, N. J.
Rees Davis Drugs, Meridan, Conn.
Reynolds & Co., R. J., Winston-Salem, N. C. 20
Roche-Organon, Inc., Nutley, N. J. 41
J. B. Roerig & Co., 536 Lake Shore Drive, Chicago
Sandoz Pharmaceuticals, New York 14
Schenley Laboratories, Inc., N. Y. 1, N. Y. 25
Schering Corp., Bloomfield, N. J. 13
Schmid, Julius, Inc., 423 W. 55th St., New York City . 43
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, 11 Canal St., Chicago 23
The Smith Dorsey Co., Lincoln, Nebr. 17
Smith, Kline & French, Philadelphia 3, 24, 35, 53
E. R. Squibbs & Co. 11
The Tarbonis Co., Cleveland 3, Ohio 36
Upjohn Co., Kalamazoo, Mich., ... 39
Walker Vitamin Products, Inc., New York 48
Wm. R. Warner & Co., 113 W. 18th St., New York .. 22
Warren-Teed Products Co., Columbus 8, Ohio
Whittaker Laboratories, Inc., New York City 5
White Laboratories, Inc.
Winthrop Stearns Co., 70 Varick St., New York 26
Wyeth Incorporated 12
Zemmer Co., Pittsburgh, Pa.

SANATORIA AND SANITARIA

The Bellevue Place, Batavia, Ill. 60
Costeff Sanatorium, Peoria, Ill. 58
Douglas Park Hospital, Chicago 57
Edward Sanatorium, Naperville, Ill. 56
Michell Farm, Peoria 57
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 56
North Shore Health Resort, Winnetka 58
Mary Pogue School, Wheaton, Ill. 59
Stokes Sanitarium, Louisville, Ky. 60

SCHOOLS

Washington University, St. Louis 10 5

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Picker X-Ray, New York 10, N. Y.
Rexair, Toledo, Ohio 34

RADIUM

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 57
Physicians Radium Assn., 55 E. Washington St., Chicago. 52
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Books Received (Continued)

Consultant in Gynaecology and Obstetrics, Beekman-Downtown Hospital, New York; Fellow of the New York Academy of Medicine. The Blakiston Company, 1012 Walnut Street, Philadelphia 5 and Toronto 2, Canada. $4.50. 259 pages. Published May 26, 1948.

SUBACUTE BACTERIAL ENDOCARDITIS: By Emanuel Libman, M.D., Late Consulting Physician, The Mount Sinai Hospital, New York City and Charles K. Friedberg, M.D., Adjunct Physician, The Mount Sinai Hospital, New York City; Edited by Henry A. Christman, A. M., M.D., LL. D., Sc. D. (Hon.), M. A.C.P., Hon. F. R. C. P. (Can.), D. S. M. (Am. Med. Assoc.) Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Sometime Clinical Professor Medicine, Tufts College Medical School; Physician-in-Chief, Emeritus, Peter Bent Brigham Hospital; Sometime Visiting Physician, Beth Israel Hospital, Boston, Mass. Reprinted from Oxford Loose-Leaf Medicine with the same page numbers as in that work. Oxford University Press, 114 Fifth Avenue, New York 11, New York. $3.50. 113 pages. Published June 10, 1948.

THE DIABETIC'S HANDBOOK: How to Work with Your Doctor; Treatment by Diet and Insulin. By Anthony M. Sindoni, Jr., M.D., Chief of the Department of Metabolism, Philadelphia General and St. Joseph Hospitals; Chairman of the Advisory Committee on Diabetes to the Director of the Department of Public Health, Philadelphia; Chief of the Diseases of Metabolism, St. Francis Hospital, Wilmington, Delaware. Introduction by Rufus S. Reeves, B.S., M.D., Director of the Department of Public Health, Philadelphia; With a foreword by Charles C. Wolferth. A.B., M.D., Professor of Medicine, School of Medicine, and Administrator of the Robinette Foundation for Research in Cardiovascular Diseases, University of Pennsylvania; Director for Cardiology, Professional Services Division, Veterans Administration; Consultant Cardiologist to the Jewish Hospital. The Ronald Press Company, New York. $3.00. 194 pages. Published June 24, 1948.

ARTERIAL HYPERTENSION: By David Ayman, M.D., Instructor in Medicine, Tufts College Medical School, Associate Visiting Physician and Head of Out-Patient Clinic in Hypertension. Beth Israel Hospital, Boston, Mass. Edited by Henry A. Christian, A.M., M.D., LL. D., Sc. D. (Hon.), M.A.C.P., Hon. F. R. C.P. (Can.), D. S. M. (Am. Med. Assoc.) Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Sometime Clinical Professor of Medicine, Tufts College Medical School; Physician-in-Chief, Emeritus, Peter Bent Brigham Hospital; Sometime Visiting Physician, Beth Israel Hospital, Boston, Mass. Reprinted from Oxford Loose-Leaf Medicine with the same page numbers as in that work. Oxford University Press, 114

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Fifth Avenue, New York 11, N. Y. $2.50. Published June 10, 1948.

THE NURSING OF TUBERCULOSIS: By O. V. Buston, S. R. N. and P.M. Maculloch Mackay, S.R.M.N., with a foreword by Richard R. Trail, M.C., M.D., F.R.C.P., Illustrated by Nora Lewis, S.R.N. Bristol: John Wright & Sons LTD. London: Simpkin Marshall (1941) LTD. $2.00. 124 pages.

CORRELATIVE NEUROANATOMY: By Joseph J. McDonald, M.S., M. Sc.D., M.D., Joseph G. Chusid, A.B., M.D., Jack Lange, M.S., M.D. Fourth Edition, Revised, 60 illustrations. University Medical Publishers, Post Office Box 761, Palo Alto, California. $3.00. 156 pages.

THE HEALTHY HUNZAS: By J. I. Rodale, Editor of Organic Gardening. Rodale Press, Emmaus, Pa. $2.75. 257 pages. Published June 15, 1948.

PRACTICAL BACTERIOLOGY, HEMATOLOGY, AND PARASITOLOGY: By E. R. Sitt, M.D., Ph. M., Sc. D., LL.D., Rear Admiral, Medical Corps, and Surgeon General, U. S. Navy, Retired. Graduate of the London School of Tropical Medicine, Formerly: President of the National Board of Medical Examiners; Head of the Department of Tropical Medicine, U. S. Naval Medical School; Associate Professor of Medical Zoology, University of the Philippines. Consultant in Tropical Medicine to the Secretary of War, World War II. Paul W. Clough, M.D., Physician-in-Charge of the Diagnostic Clinic, Johns Hopkins Hospital; Assistant Professor of Medicine, Johns Hopkins University; Associate Professor of Medicine, University of Maryland. Sara E. Branham, M.D., Ph. D., Sc. D., Senior Bacteriologist, National Institute of Health; Professional Lecturer in Preventive Medicine, The George Washington University School of Medicine; Chairman, Laboratory Section, American Public Health Association, 1946-1947 and Contributors. Tenth Edition. The Blakiston Company, Philadelphia. Toronto. 765 illustrations, numerous colored plates. $10.00. 991 pages. Published May 19, 1948.

CLINICAL LABORATORY METHODS AND DIAGNOSIS: A Textbook on Laboratory Procedures with Their Interpretation. By R. B. H. Gradwohl, M.D., D. Sc., F.R.S.T.M. & H. (London). Director of the Gradwohl Laboratories and Gradwohl School of Laboratory Technique; Pathologist to Christian Hospital; Director, Research Laboratory, St. Louis Metropolitan Police Department, St. Louis, Mo.; Commander, Medical Corps, United States Naval Reserve, RET.; Fellow, American Public Health Association. Volume III by R. B. H. Gradwohl, M.D., D. Sc., F.R.S. T. M. & H. (London) and Dr. Pedro Kouri, Director Institute of Tropical Medicine; Professor of Parasitology and Tropical Medicine; Vice-Dean of the Faculty of Medicine. Havana University; Director of Laboratories Kuba, Havana, Cuba. 3 volumes. 3300 pages, 1100 illus-

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trations and 56 color plates. $40.00. The C. V. Mosby Company, St. Louis.

DISEASES AFFECTING THE VULVA: By Elizabeth Hunt, B.A., M.D., Ch. B. (Liverp.) Honorary Consulting Dermatologist, South London Hospital for Women; Honorary Dermatologist, New Sussex Hospital for Women and Children, Brighton; Temporarily Honorary Dermatologist, Royal Infirmary, Liverpool; Formerly Senior Medical Officer, Radium Institute and Hospital for Skin and Cancer Diseases, Liverpool; Acting Honorary Dermatologist, Royal Sussex County Hospital, Brighton, Third Edition, Revised. 36 illustrations and 19 plates in colour. The C. V. Mosby Company, St. Louis. 211 pages. $7.50.

HANDBOOK OF OPHTHALMOLOGY by Everett L. Goar, A.B., M.D., F.A.C.S., Professor of Ophthalmology, Baylor University College of Medicine, Houston, Texas, with 48 text illustrations and 7 color plates. The C. V. Mosby Company, St. Louis. 166 pages. $5.50.

CLINICAL OPHTHALMOLOGY for General Practitioners and Students; By H. M. Traquair, M.D., F.R.C.S., Ed., Consulting Ophthalmic Surgeon, Royal Infirmary, Edinburgh. Ophthalmic Surgeon, Chalmers Hospital, Edinburgh. Oculist to the Edinburgh Municipal Hospitals. Late Lecturer on Diseases of the Eye, Edinburgh University. With 72 illustrations, including 8 coloured plates. The C. V. Mosby Company, St. Louis. 264 pages. $9.00.

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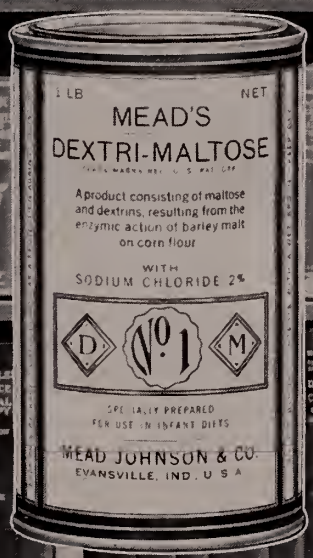
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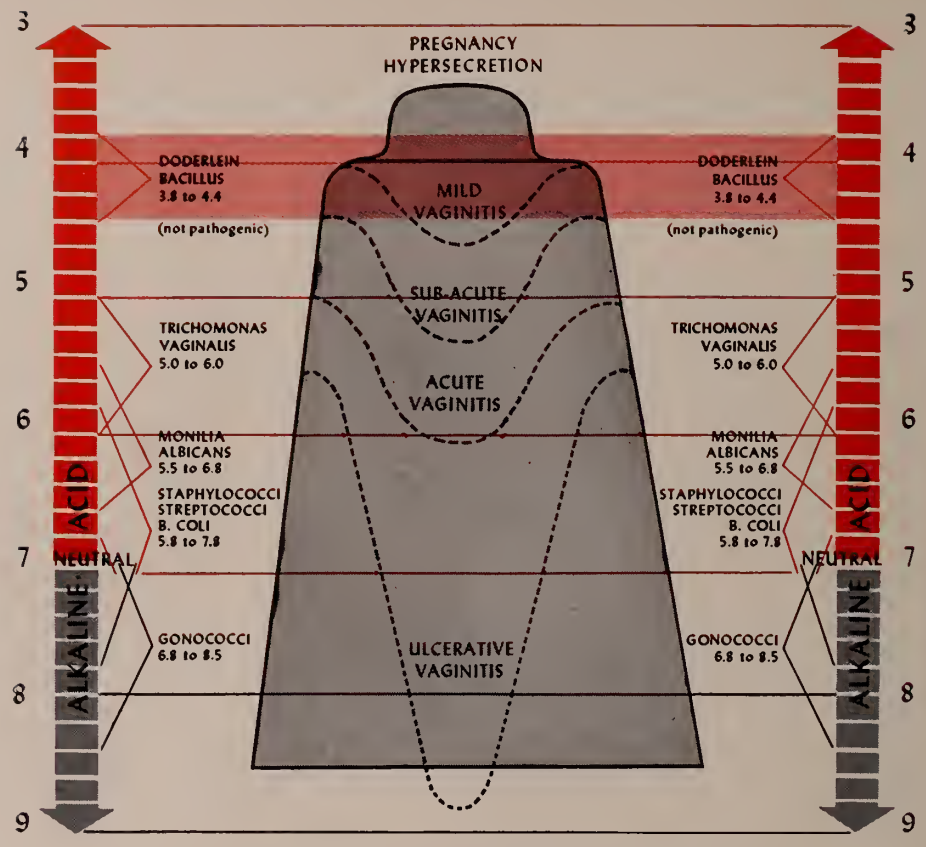
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Propyl Thiouracil in The Management of Complicated Hyperthyroidism

The Surgical Aspects of Placenta Previa

(See page 5 for complete Table of Contents)

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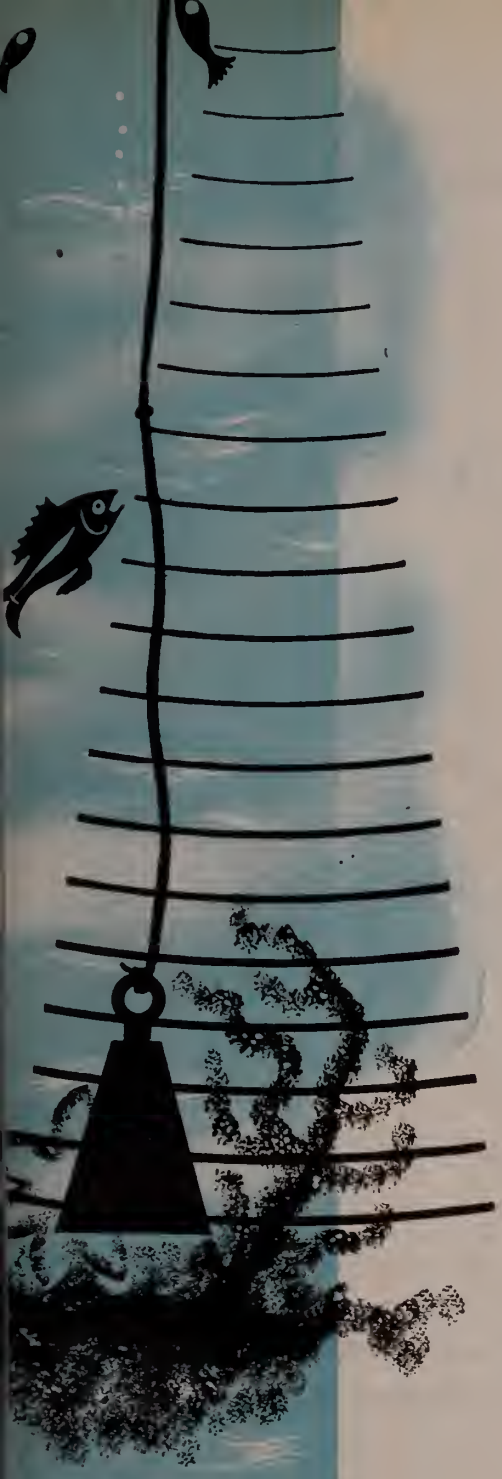
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1. Lisser, H.: *Calif. & West. Med.*, 64: 177, 1946.

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TABLE OF CONTENTS

SEPTEMBER, 1948
Vol. 94, No. 3

ORIGINAL ARTICLES

Propyl Thiouracil in The Management of Complicated Hyperthyroidism, *George M. Curtis, M.D., Arthur C. Conner, M.D.,* and *Roy E. Swenson, M.D.,* Columbus, Ohio 161

The Surgical Aspects of Placenta Previa, *Frederick H. Falls, M.D.,* Chicago 167

Progress in Cancer, *Herman L. Kretschmer, M.D., D.Sc.,* Chicago 171

Cholesterol-Basal Metabolism Determinations—Clinical Observations in 830 Cases, *James H. Hutton, M.D.,* and *Stanley Fahlstrom, M.D.,* Chicago 176

Thrombophlebitis and Phlebothrombosis, *Garland O. Welland, M.D.,* Rockford 180

Ovarian Thecoma: Case Reports with Contrasting Symptomatology, *Charles L. Patton, M.D., F.A.C.S.,* and *Robert J. Patton, M.D., M.S., F.A.C.S.,* Springfield 184

Laboratory Methods Useful in the Differential Diagnosis of Chronic Chest Diseases, *Henry C. Sweany, M.D.,* and *J. Robert Thompson, M.D.,* Chicago 189

Appendiceal Lithiasis, Case Report, *Benjamin F. Hoopes, M.D., F.A.C.S.,* Bloomington 192

EDITORIALS

Selecting The Outstanding General Practitioner .. 149

The Interim Session of the American Medical Association 150

History of Medicine in Illinois 150

Book Reviews 54

MEDICAL ECONOMICS

Pre-Marital Tests and Marriage Counseling 153

STATE DEPARTMENT OF PUBLIC HEALTH

Disasters Without Disease 155

CORRESPONDENCE

Graduate Course in Endocrinology 157

Siliform Ampuls Potentially Dangerous 157

Chest Physicians Elect Officers 157

Invitation to Michigan's Annual Meeting 158

Director for Mental Hygiene Section Sought 158

Naval Air Reserves Needs Doctors 158

Active Duty Billets 158

Woman's Auxiliary 159

INDUSTRIAL HEALTH

Occupational Disease in Differential Diagnosis, *H. T. Castberg, M.D., U.S.P.H.S.* 195

PHYSICAL MEDICINE ABSTRACTS 42

NEWS OF THE STATE 199

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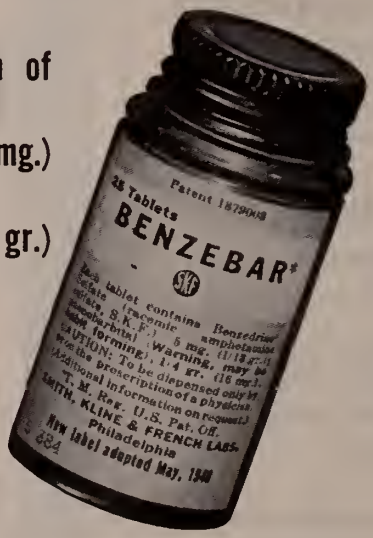
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1. Pierce, R. R.: Am. J. Obst. & Gynec. vol. 55 (Feb.) 1948.

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*Wooldridge, W. E.: The Gamma Isomer of Hexachlorocyclohexane in the Treatment of Scabies, J. Invest. Dermat. *10*:363 (May) 1948.

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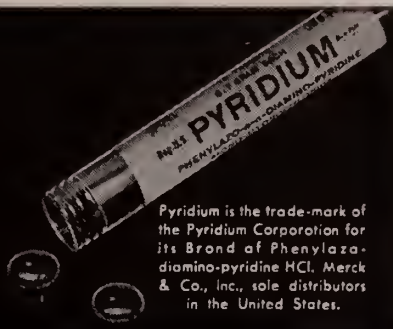
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MERCK & CO., Inc. RAHWAY, N. J.

Manufacturing Chemists

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Physician's package and complete description of the *New Technique* will be sent upon request.

Ethically promoted—Advertised only to the medical profession.



Accepted by the Council on Physicol Medicine of the Americon Medicol Association.

Easily Fitted—The Lanteen Flat Spring Diaphragm, collapsible in one plane only, is easily placed without an inserter.

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LANTEEN MEDICAL LABORATORIES, INC.

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96-Hour Penicillin Blood Levels with

Flo-Cillin "96"

Here is a revolutionary improvement in repository penicillin formulations: *a single 1 cc. injection (300,000 units) produces and maintains therapeutic blood concentrations for 96 hours in 90% of patients.* This outstanding achievement does away with the need for every day injections in repository penicillin therapy; the recommended dosage of a single 1 cc. injection *every other day* is judged to be adequate for the majority of clinical purposes.

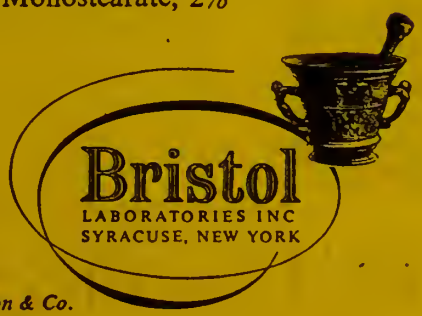
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Flo-Cillin "96" is a stable, always fluid suspension which doesn't "settle out." No extemporaneous mixing or prolonged shaking is required. A uniform dispersion of penicillin is assured in each and every dose.

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Procaine Penicillin G in Oil
(300,000 units per cc.)
with Aluminum Monostearate, 2%

Available NOW from your usual source in vials containing ten 1 cc. doses; in a sterile disposable package containing a 1 cc. cartridge and one B-D Disposable Cartridge Syringe; and in 1 cc. cartridges alone for use with the B-D* Metal Cartridge Syringe.*



**Reg. U. S. Pat. Off., Becton, Dickinson & Co.*

Experience is the Best Teacher

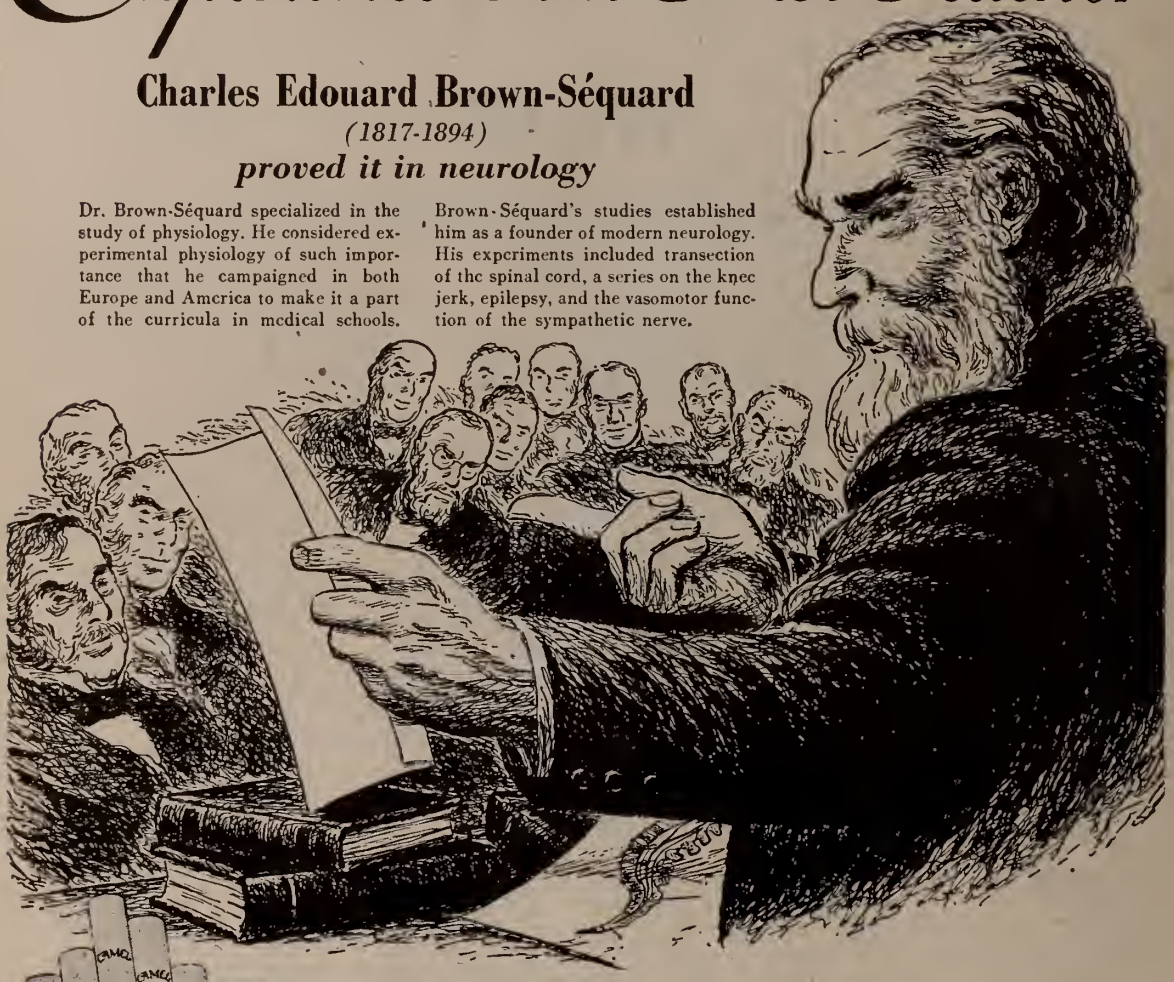
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(1817-1894)

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Dr. Brown-Séquard specialized in the study of physiology. He considered experimental physiology of such importance that he campaigned in both Europe and America to make it a part of the curricula in medical schools.

Brown-Séquard's studies established him as a founder of modern neurology. His experiments included transection of the spinal cord, a series on the knee jerk, epilepsy, and the vasomotor function of the sympathetic nerve.





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Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.



an entirely new approach to the treatment of pain

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EDRISAL contains two analgesics of established effectiveness. But, just as important, it also contains the logical anti-depressant, Benzedrine* Sulfate. Thus Edrisal not only relieves your patient's organic pain, but also relieves his anxiety over it. In Edrisal, therefore, you have a unique weapon—a double-barreled weapon—for the relief of pain.

Each Edrisal tablet contains acetylsalicylic acid (2.5 gr.), phenacetin (2.5 gr.), and 'Benzedrine' Sulfate (2.5 mg.). For samples and full information, write us at 429 Arch St., Philadelphia 5, Pa.

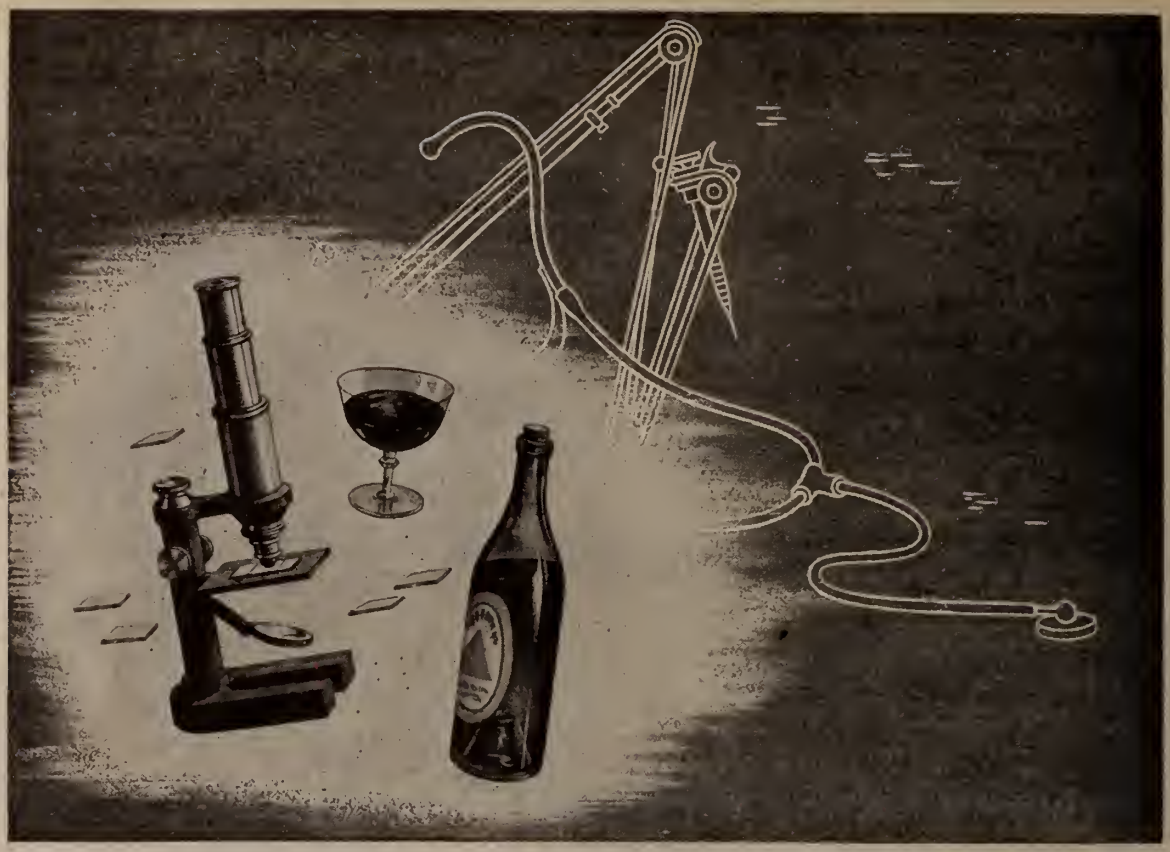
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its dual action relieves pain • lifts mood

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Medicine and Dentistry honor Louis Pasteur (1822-1895) and Robert Koch (1843-1910) as the co-founders of bacteriological science.

Pasteur proved that certain micro-organisms present in the air caused the fermentation of milk, wine and beer . . . that certain animal diseases were spread by still other bacteria. His reports stimulated valuable research into the new science by others—notably Lord Lister, who grasped their significance for surgery and introduced sterilization to the operating table in 1865.

Koch, the young German physician whose fancy turned to germ-study when his wife gave him a microscope for his birthday, developed an accurate and scientific method for the separation of pure cultures of disease-bacteria, and for their use in animal inoculation. Discovery of the germs of the more common diseases, and protective measures against them, were rapid after 1880.

Doctors Since 1899 also have been gratified by the rapid development of protective measures against malpractice claims and lawsuits. The Medical Protective policy offers *complete* protection, *preventive* counsel and *confidential* service.

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Professional Protection EXCLUSIVELY . . . *since 1899*

CHICAGO: T. J. Hoehn, E. M. Breier and W. R. Clouston, Representatives, 1142-44 Marshall Field Annex Bldg., Tel. State 0990—SPRINGFIELD: F. A. Seeman, Representative, 307 Illinois National Bank Bldg., Tel. 7915



"We eat what we choose or must, not according to the National Research Council."[1] But we can *treat* the resulting vitamin deficiencies as we choose, *and* in exact accordance with F.D.A. nutritional standards.

Sharp & Dohme has used exactly 5 times the F.D.A. minimum daily vitamin requirements as the basis of MULSAVITE[2] Capsules Therapeutic Potency Multivitamins:

	MULSAVITE Capsules	F.D.A. Requirements
Vitamin A	20,000 units	4,000 units
Vitamin D	2,000 units	400 units
Thiamine hydrochloride	5 mg.	1 mg.
Riboflavin	10 mg.	2 mg.
Pyridoxine hydrochloride	1 mg.	•
Calcium pantothenate	10 mg.	•
Niacinamide	50 mg.	•
Ascorbic Acid	150 mg.	30 mg.
Mixed tocopherols	10 mg.	•

• No daily requirement established

Jolliffe and Smith stress that "The daily therapeutic dose of vitamins should be at least five times the maintenance requirements. Since they can be given in amounts many times the maintenance requirements without untoward effect, it is better to give too much than too little."[3]

MULSAVITE Capsules are indicated for treatment of concurrent multiple vitamin deficiencies. The dose is one capsule or more daily. Bottles of 30 and 500 easily swallowed capsules. Sharp & Dohme, Philadelphia 1, Pa.

1. Haven Emerson: Journal Lancet, 57:1, 1947. 2. Registered trademark, Sharp & Dohme. 3. M. Clin. North America 27:567, March 1943.

MULSAVITE

Prompt Relief of Anorectal Pain



'anusol'*



hemorrhoidal suppositories

Hemorrhoids can be considered part and parcel—if, indeed, not a penalty—of the modern tempo of living. It has been said that more than 50% of all people in middle life either have or have had hemorrhoids.

In the palliative treatment of this common disorder or in simple, uncomplicated rectal irritations and inflammations 'Anusol' Hemorrhoidal Suppositories have been time-tried and have proved their clinical value over a period of many years.

The prompt and soothing relief afforded by 'Anusol' Hemorrhoidal Suppositories is due to the emollient, mildly astringent, and antiseptic actions provided by the components of the well balanced formula. The effective blending of purely local actions quickly allays anorectal pain and discomfort without evoking undesirable systemic by-effects.

Bismuth subgallate	2.25%
Bismuth-resorcin compound	1.75%
Nicaraguan balsam (medicinal) . . .	3.00%
Zinc oxide	11.00%
Boric acid	18.00%
Cacao butter ointment base q.s. ad	100.00%

The small diameter and cylindrical shape of 'Anusol' Hemorrhoidal Suppositories render their insertion easy and painless. Melting at body temperature and providing a soft, soothing, unctuous covering over the engorged hemorrhoids or irritated rectal mucosa, 'Anusol' Hemorrhoidal Suppositories have a prompt, beneficial, therapeutic action resulting in almost immediate relief.

How Supplied: 'ANUSOL' Hemorrhoidal Suppositories are supplied in boxes of 6 and 12 suppositories.

* T. M. Reg. U. S. Pat. Off

OMNIS ORBIS WARNER

Wm. R. Warner & Co., Inc.
New York · St. Louis

"safety zone"

therapy of

PEPTIC ULCER



The gastric pH range which is safe for the peptic ulcer patient lies between 4 and 5. In this "safety zone" there is neither pepsin activity (which may cause continued erosion or bleeding) nor stimulation of excess acid production.

Tricreamalate, a balanced blend of aluminum hydroxide gel with magnesium trisilicate reduces acidity within the stomach to pH 4 to 5. Absolute neutrality is not reached. Hence, there is no stimulus to "acid rebound" and no alkalosis.

Through the formation of a protective coating and a mild astringent effect, nonabsorbable Tricreamalate is soothing to the irritated gastric mucosa, relieves gastric pain and heartburn, and aids in healing peptic ulceration as well as in preventing recurrence.

Tricreamalate

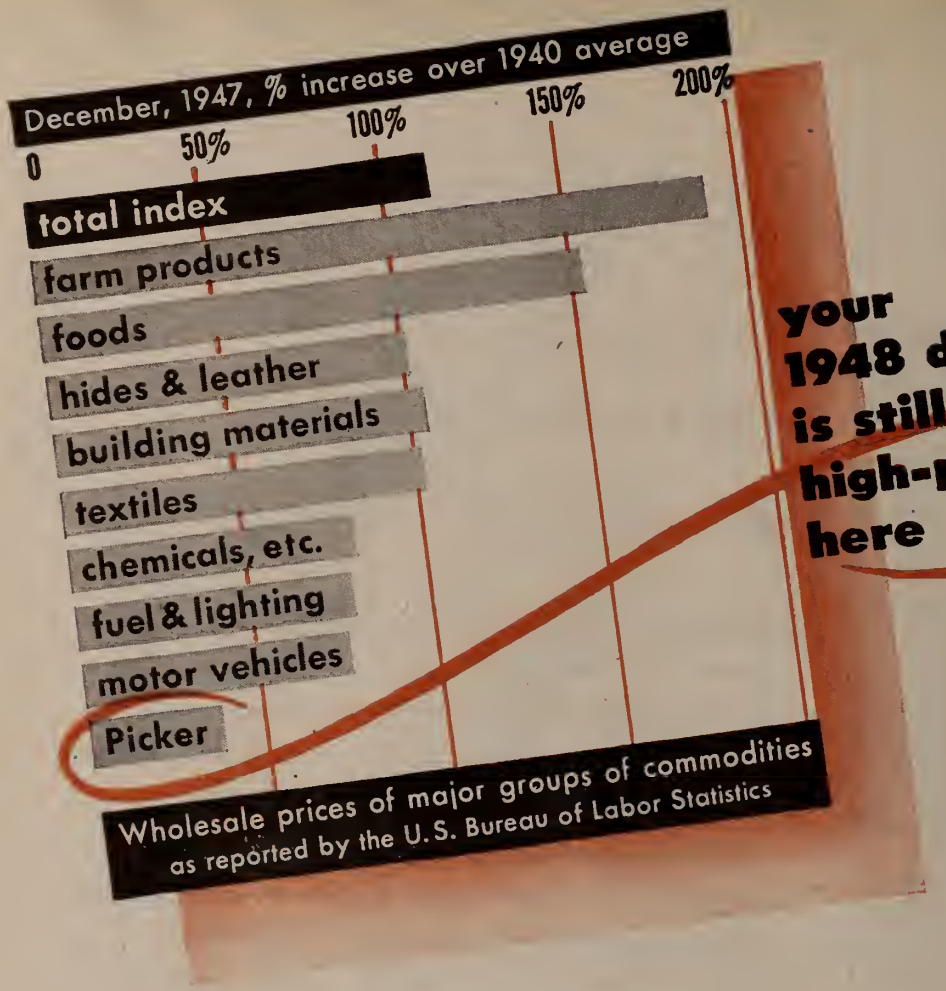
Aluminum Hydroxide Gel with Magnesium Trisilicate

LIQUID
Bottles of 12 fl. oz.
TABLETS
Tins of 12
Bottles of 100 and 500

Dose: 1 or 2 teaspoonfuls or tablets every 2 to 4 hours.

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Tricreamalate, trademark



Maybe you're leary of comparative statistics: you've seen them used too often as pious justification for price boosts. But here's a set that's refreshingly different: it shows how successfully Picker has maintained the purchasing power of your 1948 x-ray dollar. It's as true today as it always has been . . . ***an investment in Picker x-ray apparatus is an investment in consistently high performance over an exceptionally long life.***

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for the convalescent



hemoglobin build-up

PLUS nutritional support

Slow regeneration of blood is one of the most frequent—and often unappreciated—reasons for delayed and inadequate convalescence after both acute and prolonged illnesses as well as after surgery. This is not surprising since even in otherwise healthy individuals a drop of only 10 or 15 percent in the hemoglobin level commonly produces definite asthenia and easy fatigability. Cytora is of particular value for convalescents because it provides important factors necessary for rebuilding blood plus other dietary essentials; each Cytora tablet supplies liberal quantities of iron, folic acid, liver concentrate, vitamin C and five B-complex factors. The pharmaceutical skill exercised in compounding Cytora tablets assures optimal absorption of the active ingredients and minimizes gastric disturbances. Cytora also eliminates a senseless multiplication of medications for the convalescent who might otherwise require several individual medicinal agents to rebuild his blood and improve his nutrition. Cytora is available in bottles of 100, 250, and 1000 tablets.

ROCHE-ORGANON INC., ROCHE PARK, NUTLEY 10, N. J.

CYTORA

'Roche=Organon'

T. M—Cytora — Reg. U. S. Pat. Off.

DAILY DOSE (6 TABLETS) PROVIDES:	
Ferraus Sulfate	600.0 mg
Folic Acid	4.5 mg
Liver Concentrate	900.0 mg
Vitamin C	150.0 mg
Vitamin B_1	6.0 mg
Vitamin B_2	6.0 mg
Vitamin B_6	3.0 mg
Niacinamide	30.0 mg
Calcium Pantothenate	6.0 mg

plus other factors naturally present in liver concentrate

Available in bottles of 100, 250 and 1000

MEAT...

And the Nutritional Significance of Fat

The all too prevalent practice of trimming the fat from many meat cuts and discarding it not only represents unnecessary economic, but also nutritional, waste. Fat is nutritionally valuable for several reasons, some of them well known, some only recently appreciated.

The fat of meat is an outstanding source of caloric food energy, small in bulk and low in moisture. It carries important fat-soluble vitamins, is well digested and absorbed, and endows the meal with satiety value making for real satisfaction. Meat fat furthermore contains certain unsaturated fatty acids which appear to play a significant and essential part in skin metabolism. Fat also exerts a sparing effect with regard to B complex vitamins.

Recent evidence[1,2] indicates that the presence of fat in a mixed dietary considerably decreases the specific dynamic effect of the three basic nutrients, thus promoting optimal utilization of the protein ingested.

This survey of the nutritional significance of fat again emphasizes the valuable role of meat fat in the daily dietary.

[1] Forbes, E. B., and Swift, R. W.: J. Nutrition *27*:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition *31*:203;213 (Feb.) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago...Members Throughout the United States



When more than one form of anemia is present or suspected

LIAFON

SQUIBB

desiccated liver
ferrous sulfate
ascorbic acid
folic acid

Cartwright[1] points out that "the absence of certain dietary essentials retards erythrocyte formation and the addition of these essentials to diet accelerates it." Liafon supplies four erythropoietic essentials in one capsule:

WHOLE LIVER (desiccated) — with nothing but the water removed — to supply the secondary antianemia fractions which have been proved to be essential experimentally and clinically.

FERROUS SULFATE (exsiccated) — to supply the most easily tolerated, best absorbed and most completely utilized essential for specific therapy of iron deficiency anemias.

ASCORBIC ACID — which is intimately associated with red blood cell formation — which aids in the absorption and utilization of iron — and which is often a prerequisite in anemias complicated with C avitaminosis.

FOLIC ACID — for bone marrow stimulation and to complete the development of red blood cells — as specific therapy for macrocytic anemias of malnutrition, pregnancy, pellagra and sprue.

1. Cartwright, G. E.: Blood 2:111 (March) 1947.

EACH LIAFON CAPSULE CONTAINS:	DOSAGE EQUIVALENTS	
	3 capsules daily	6 capsules daily
Desiccated Liver 0.5 Gm. (Approx. equivalent to 2 Gm. whole fresh liver)	6 Gm. fresh liver	12 Gm. fresh liver
Ferrous Sulfate Exsiccated . . . 2.0 gr. (Approx. equivalent to 2.85 gr. ferrous sulfate or 38 mg. elemental iron)	8.5 gr. ferrous sulfate	17 gr. ferrous sulfate
Ascorbic Acid 50.0 mg.	150 mg.	300 mg.
Folic Acid 1.67 mg.	5 mg.	10 mg.

SQUIBB

Liafon is supplied in bottles of 100 and 1,000

"Imprisoned in every fat man,
a thin one
is wildly signaling to be let out."

C. C. Palinurus, quoted in Bull. New York Acad. Med. 24:2 (Feb.) 1948.



Overeating imprisons the "thin one", and he can signal till doomsday, but he will never get out unless the "fat man" stops overeating.

'Dexedrine' Sulfate curbs appetite, makes it easy for the overweight patient to stop overeating and thus reduces weight safely without the use (and risk) of such potentially dangerous drugs as thyroid.

Dexedrine Sulfate Tablets & Elixir

The most effective drug for control of appetite in weight reduction

Smith, Kline & French Laboratories Philadelphia

'Dexedrine' T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

Miss Dodge sneaks her breakfast at 10



THE boss frowns on going out for coffee, but Miss Dodge *has* to have her doughnut-and. After all, she can't go without breakfast, can she? So Miss Dodge and the vast horde of others for whom proper diet is something for doctors to worry about continue to forget nutrition. Sooner or later, many of them wind up as subclinical vitamin deficiency cases. Your first thought, properly, is dietary reform. But, for added assurance, many physicians are also prescribing a vitamin supplement—in a form that is small and easy to take. This valuable supplement is Dayamin, Abbott's potent multivitamin capsule. Each capsule contains six essential vitamins in amounts equal to the daily *optimum* requirement for adults—plus pyridoxine and pantothenic acid. One capsule daily as a supplement—or in slightly larger doses for therapeutic use. Dayamin is supplied by the nation's prescription pharmacies in bottles of 30, 100 and 250 capsules. Palatable Dayamin Liquid is also available—in bottles of 90 cc., 8 fluidounces and 1 pint. Remember the name—Dayamin. ABBOTT LABORATORIES, North Chicago, Ill.

SPECIFY

Dayamin®

(ABBOTT'S MULTIPLE VITAMINS)

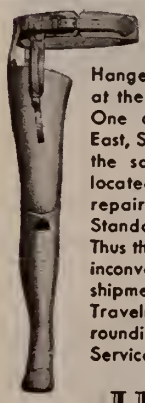
Each Dayamin capsule contains:

Vitamin A	10,000 U.S.P. units
Vitamin D	1000 U.S.P. units
Thiamine Hydrochloride	5 mg.
Riboflavin	5 mg.
Nicotinamide	25 mg.
Pyridoxine Hydrochloride	1.5 mg.
Pantothenic Acid (as Calcium Pantothenate)	5 mg.
Ascorbic Acid	100 mg.

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provides service and repairs

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Wherever the Hanger Wearer may live or travel, he can feel assured that his Hanger Artificial Limb will be properly serviced at the nearest Hanger office.

One or more offices in every section—North, East, South, and West—render Hanger Wearers the same high quality service. Conveniently located in many key cities, each offers complete repair facilities and carries a full line of Hanger Standard parts and supplies.

Thus the Hanger Wearer is caused a minimum of inconvenience and discomfort. Long waits for shipments from distant factories are eliminated. Traveling representatives cover many areas surrounding the offices. In such areas, Hanger Service is brought literally to Hanger Wearers.

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35 Years' Service to the Cancer Therapist

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Modern Laboratories and Equipment; Experienced Technical Staff; Orders Accurately and Promptly Executed.

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4

HEMABOLOIDS®

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FORMULAS

Hematinic Therapy to Meet Individual Requirements

Presenting iron in readily assimilable protein combination. Cause no puckering, griping, gastric upsets, discoloration of teeth, or constipation.

Palatable • Well Tolerated

Arlington

Tablets **HEMABOLOIDS** *with* Folic Acid

Each tablet represents:
Iron (as prateinate)..... 50 mg.
Folic Acid..... 5 mg.

HEMABOLOIDS *with* Liver Concentrate

Each fluid ounce represents:
Alcohol (by volume)..... 17%
Iron (as prateinate)..... 120 mg.
Liver Concentrate (20:1)..... 500 mg.
Cane sugar, glycerine, flavoring...aa...q.s.

Tablets **HEMABOLOIDS** *with* Liver Concentrate

Each tablet represents:
Iron (as prateinate)..... 35 mg.
Liver Concentrate (20:1)..... 100 mg.

HEMABOLOIDS
ARSENIATED

Each fluid ounce represents:
Alcohol (by volume)..... 17%
Arsenous Acid..... 1/20 gr.
Iron (as prateinate)..... 120 mg.
Cane sugar, glycerine, flavoring...aa...q.s.

THE ARLINGTON CHEMICAL COMPANY, YONKERS 1, NEW YORK



A Supplement to Fine Surgery

APPLICATION of Tincture 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) to the operative field assures rapid elimination of many pathogenic organisms. Extra protection is afforded because 'Merthiolate' continues to inhibit and destroy organisms as they are released from sebaceous and sweat glands during the surgical procedure. 'Merthiolate' does not coagulate tissue proteins. Significant, too, is its compatibility with soap and other defatting agents.

'Merthiolate,' the many-purpose antiseptic, is available in the following convenient-to-use preparations:

'Merthiolate' Tincture	1:1,000
'Merthiolate' Solution	1:1,000
'Merthiolate' Jelly	1:1,000
'Merthiolate' Ophthalmic Ointment	1:5,000
'Merthiolate' Suppositories	1:1,000

Lilly

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.



A 15 x 12 reproduction of this Robert Riggs illustration is available upon request.

Lilly in Denmark

THE ADVENT of Protamine Zinc Insulin in 1936 added materially to the well-being and comfort of diabetic patients in whom it has since been employed. The basic research which made this achievement possible was accomplished by Dr. H. C. Hagedorn and his associates, of Copenhagen. Eli Lilly and Company has co-operated fully in its elaboration for over a decade.

In 1946, distribution of Lilly products to the Danish medical and pharmaceutical professions began. The Lilly Research Laboratories offer Danish physicians their full co-operation in the development of new and superior medicinal agents. Physicians in the United States will be certain to share in any practical innovations which may be forthcoming.

LILLY INTERNATIONAL

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 3 September, 1948

NEW PROCEDURE FOR SELECTING OUTSTANDING GENERAL PRACTITIONER

At the meeting of the House of Delegates of the American Medical Association in Chicago last June, a resolution was introduced by Edwin S. Hamilton of the Illinois delegation recommending a procedure for the selection of the outstanding general practitioner so that there would be one candidate from each of the several states and territorial possessions.

The resolution was adopted as presented, and each state medical society is asked to submit its nomination to the A.M.A. not later than November 15, to be considered at the St. Louis Interim Session November 30 to December 3.

Under this adopted plan

(1) Each county medical society shall be urged to name the candidate of its choice as the outstanding general practitioner for the year within its jurisdiction, basing its selection on nominations and recommendations from any responsible source, lay or professional.

(2) The name of each candidate so chosen by a county medical society, with all pertinent data, including recommendations of lay groups and individuals, shall be submitted by the county medical society to the state medical society of which it is a component part.

(3) Each state medical society through whatever agency each may designate, shall select from among the candidates submitted by its component county medical societies one name to be declared the outstanding general practitioner within the state.

(4) The candidate so selected at the state level shall be the sole candidate from that state, and his or her name, with all pertinent supporting data shall be submitted to the Board of Trustees of the American Medical Association.

(5) The Board of Trustees shall select from the names submitted by state societies, the names of three persons, these names to be submitted in turn to this House of Delegates, which shall select one name to be declared the outstanding general practitioner of the United States for the year.

(6) Any state medical society desiring to do so may establish and confer a suitable award with fitting public ceremony on the physician it has named as the outstanding general practitioner of that state for the year.

This information has been submitted to all county society secretaries in Illinois, and it is hoped that names of the candidates from the individual county levels will be submitted to the State Society Secretary's office not later than October 15.

THE INTERIM SESSION OF THE AMERICAN MEDICAL ASSOCIATION

The Interim Session of the American Medical Association will be held at St. Louis, November 30 to December 3, 1948. The first Interim Session was held in Cleveland last January when a full two day program was arranged for the general practitioner. This general plan is to be carried on in the future.

For many years the annual conference of State Society Secretaries and Editors has been held at the A.M.A. headquarters in Chicago during November. According to present plans, this annual conference will be held in St. Louis on Sunday and Monday, November 28 and 29.

Another interesting new feature which has been added for the Interim Session is the scheduling of the first national Medical Public Relations Conference under sponsorship of the A.M.A. A full day program will be presented on Saturday, November 27. With the ever increasing number of societies adding public relations counsels to their executive staffs, it seems quite important that these officials get together and establish definite projects which all societies can use in their public relations work. Many have commented during recent years on the apparent lack of uniformity in the prevailing ideas concerning medical public relations, and it is desirable for the public relations counsels to get together and discuss the subject.

The theme for this conference is "Shooting at Common Targets in Medical Public Relations." Conference plans are in the hands of Mr. Lawrence W. Rember, director of the A.M.A. public relations and executive assistant to the Secretary and General Manager.

Every state medical society now having a public relations counsel or proposing to add such an executive to its staff within coming months, will profit by sending representatives to this conference. Likewise chairmen of committees on public relations will be present and participate in the deliberations. During the afternoon session, six major social issues of general interest to the various state societies will be discussed thoroughly by members of the group.

Much is to be learned in the field of medical public relations; although there are problems of less importance in some states than in others, the projects must necessarily be developed to fit actual needs, and it will be of much value to all of the societies to have generally accepted procedures to follow in order to gain proper experience in determining the most desirable public relations programs of the future.

Those who have attended recent sessions of the A.M.A. House of Delegates realize the importance of a midyear session. This was clearly demonstrated at the session in Cleveland last January when the House had two full days of deliberation on many important subjects. Two full days are assigned for the St. Louis session again this year.

Scientific programs will be presented, and physicians attending the Interim Session will be well repaid for the time and effort expended in order to be among those present on this occasion.

HISTORY OF MEDICINE IN ILLINOIS

The Illinois State Medical Society Committee on Medical History has been holding regular meetings and has made various assignments in an effort to secure all possible historical data throughout the state. Under the chairmanship of James H. Hutton, the committee personnel is as follows: James H. Hutton, Chairman, 30 N. Michigan Avenue, Chicago, J. J. Moore, 55 E. Washington Street, Chicago, David J. Davis, 721 Elmwood Avenue, Wilmette, Charles P. Blair, Monmouth, D. D. Monroe, Alton, E. H. Weld, Rockford, Harold M. Camp, Monmouth, George H. Coleman, 122 S. Michigan Ave., Chicago, J. P. Simonds, 303 East Chicago Ave., Chicago.

Ex-officio: Percy E. Hopkins, President, 800 West 78th Street, Chicago, Harry M. Hedge, Chairman of the Council, 30 N. Michigan Ave., Chicago.

The Illinois State Medical Society published a "History of Medical Practice in Illinois" in 1927 which included historical information up to 1850. The Committee with Council approval, intends to produce the second volume beginning with 1850. Historical data is contained in the large collection of information now housed at the Illinois State Historical Library in Springfield. A lot of this material was originally collected by the late Carl E. Black of Jacksonville, and is entered at the library as the Carl E. Black-Illinois State Medical Society collection. Suitable filing cabinets have been purchased to store

the photographs in the collection, and they have all been catalogued properly. Biographic data accompanies each picture. Several thousand photographs of present members of this Society have been added to the collection during recent years, and as these are received from the official photographer, they are sent to the State Historical Library.

Each county medical society has been asked to name an historian, and replies have been received from most of the county societies. All types of information has been sent from the secretary's office to the historians to acquaint them with their duties so that this work can go forward quickly. These county historians are asked to get information relative to living physicians within their respective counties. They have been urged to confer with the elderly physicians who can add materially to the store of historical data now available.

The Woman's Auxiliary to the Illinois State Medical Society has been asked to aid in this important project. They have been delegated the responsibility of procuring information concerning former physicians, now deceased. Biographic forms have been printed and sent to both the county society historians and to each Auxiliary president. Sources of information are the libraries, newspaper offices where cumulative files of papers are available, county histories which were published in most Illinois counties from 1870 to 1900, and from the families of the physicians.

There are many valuable records in the homes of descendents of early Illinois physicians which should be sought in every county.

With the approval of the Council, Miss Ella Salmonsen, 6732 Newgard Avenue, Chicago 26, has been selected to act as the official compiler to receive this information which will be catalogued and used as the basis for the printed volume.

At a later date when more material is available and catalogued, efforts will be made to select an editor to assume responsibilty for writing the book. Illinois physicians or others having information which they believe will be of value to the Committee are urged to write to Dr. James H. Hutton as chairman of the committee, to Miss Salmonsen as compiler, or to the state society secretary's office in Monmouth.

The list of county society historians and the Woman's Auxiliary president is presented so that physicians anywhere in Illinois may know who is responsible in each county for procuring the desired biographic material.

COUNTY MEDICAL SOCIETY "HISTORIANS"

Adams County: — Dr. E. B. Montgomery, 134 North 8th Street, Quincy, Illinois
Alexander County:
Bond County: — Dr. Kate B. Luzader, East College Ave., Greenville
Boone County: — Dr. M. L. Hartman, 511 S. State Street, Belvidere, Illinois
Bureau County: — Dr. O. J. Flint of Princeton, Dr. C. C. Barrett of Princeton (2)
Carroll County: — Dr. J. B. Schreiter, First Natl. Bank Bldg., Savana
Cass County: — Dr. D. E. Haworth, 115 West 4th Street, Beardstown, Illinois
Champaign County: — Dr. James S. Mason, 129 W. Elm Street, Champaign, Illinois
Cook County: — Dr. J. P. Simonds, Chairman, 303 E. Chicago Avenue, Chicago, Illinois
Aux Plaines Branch: — Dr. Ellis Kerr, 715 Lake Street, Oak Park, Illinois
Calumet Branch: — Dr. E. D. Huntington, 10450 S. Prospect Ave., Chicago
Douglas Park Branch:
Englewood Branch: — Dr. Eugene F. Carey, 6856 S. Halsted St., Chicago
North Suburban Branch: — Dr. Dwight Clark, 636 Church Street, Evanston, Illinois
Irving Park Branch: — Dr. Ernst Hoffman, 4013 Milwaukee Ave., Chicago, Illinois
Jackson Park Branch: — Dr. Frank P. Hammond, 11 S. LaSalle St., Chicago 90, Illinois
North Shore Branch: — Dr. H. Kenneth Scatliff, 4753 Broadway, Chicago, Illinois
North Side Branch: — Dr. Chas. H. Parkes, 1910 N. Lincoln Ave., Chicago
Northwest Branch: — Dr. Chas. F. Stotz, 4408 Parker Ave., Chicago*
South Chicago Branch: — Dr. Hugh N. Mackechnie, 5805 S. Dorchester, Chicago, Illinois, Dr. W. J. Nixon Davis, 2636 East 75th Street. Chicago Illinois
South Side Branch:
Southern Cook County: — Dr. R. C. Aiken, First Natl. Bank, Blue Island
Stock Yards Branch: — Dr. Antony J. Bertash, 4826 S. Kimbark, Chicago, Illinois
West Side Branch: — Dr. Wade C. Harker, 4458 W. Madison St., Chicago
Christian County: — Dr. G. L. Armstrong, 302 East Market St., Tayorville, Illinois
Clark County: — Dr. L. J. Weir, Marshall, Illinois
Clay County: — Dr. N. W. Bowman, Flora, Illinois
Clinton County: — Dr. J. Q. Roane, First Natl. Bank, Carlyle

*Deceased

Coles-Cumberland County: — Dr. G. B. Dudley, Charleston, Illinois
Crawford County:
DeKalb County: — Dr. Clifford Smith, DeKalb, Illinois
Dewitt County: — Dr. W. R. Marshall, 115 N. Quincy Street, Clinton, Illinois
Douglas County: — Dr. J. H. Taylor, Villa Grove, Illinois
Du Page County: — Dr. M. F. Heidgen, Memorial Hospital, Elmhurst, Illinois
Edgar County: — Dr. Frank Link, 205 N. Central, Paris, Illinois
Edwards County: — Dr. R. L. Moter, Albion, Illinois
Effingham County: — Dr. Henry Taphorn, Effingham, Illinois
Fayette County: — Dr. Mark Greer, Fehren Building, Vandalia, Illinois
Ford County: — Dr. M. D. E. Peterson, Paxton, Ill.
Franklin County: — Dr. C. O. Lane, West Frankfort, Illinois
Fulton County: — Dr. W. E. Shallenberger, Canton, Illinois
Gallatin County: — Dr. W. F. Stanelle, Shawneetown, Illinois
Greene County: — Dr. Paul A. Daley, Carrollton, Illinois
Hancock County: — Dr. H. V. Prescott, Dallas City, Ill.
Hardin County:
Henderson County:
Henry County: — Dr. G. H. Hoffman, Kewanee, Illinois, Dr. John Wead, Wyoming, Illinois
Iroquois County:
Jackson County: — Dr. Wm. D. Mohlenbrock, 114 N. 14th St., Murphysboro, Illinois
Jasper County: — Dr. W. E. Franke, Newton, Illinois
Jefferson-Hamilton County:
Jersey County: — Dr. H. R. Bohannan, Jerseyville, Illinois
Jo Daviess County: — Dr. C. G. Buford, Elizabeth, Illinois
Johnson County: — Dr. C. D. Nobles, Anna St. Hospital, Anna
Kane County: — Dr. K. M. Manougian, Professional Bldg., Elgin, Illinois
Kankakee County:
Knox County: — Dr. E. N. Nash, Hill Arcade, Galesburg, Ill.
Lake County: — Dr. Theodore Proxmire, Lake Forest, Ill.
LaSalle County: — Dr. J. S. Geen, Utica, Illinois
Lawrence County: — Dr. E. Fahnestock, Bridgeport, Illinois
Lee County: — Dr. A. F. Moore, 115 Galena Ave., Dixon
Livingston County: — Dr. A. B. Middleton, Clermont, Florida
Logan County: — Dr. D. M. Barringer, Scully Bldg., Lincoln.
McDonough County: Dr.W. M. Hartman, Macomb, Ill.
McHenry County:
McLean County: — Dr. A. E. Livingston, 219 N. Main Street, Bloomington, Illinois
Macon County: — Dr. C. Martin Wood, 104 N. Water Street, Decatur, Illinois
Macoupin County: — Dr. Joseph J. Grandone, 105½ W. Chestnut, Gillespie, Illinois
Madison County: — Dr. D. D. Monroe, Alton
Marion County: — Dr. H. L. Logan, Salem, Illinois
Mason County:
Massac County: — Dr. W. S. Dixon, 6th & Market. Metropolis
Menard County: — Dr. H. K. Moulton, 119 N. Main Street, Petersburg, Illinois
Mercer County: — Dr. V. A. McClanahan, Aledo, Illinois
Monroe County: — Dr. E. H. Schaller, Waterloo, Illinois
Montgomery County: — Dr. L. G. Allen, 400 Monroe, Litchfield
Morgan County: — Dr. C. Ellsworth Black, 203 Farmers Bank, Jacksonville, Illinois
Moultrie County: — Dr. J. F. Lawson, Sullivan, Illinois
Ogle County: — Dr. W. E. Kittler, Rochelle, Illinois
Peoria County: — Dr. Rolland L. Green, Central Natl. Bank, Peoria, Illinois
Perry County: — Dr. Clarence F. Kelly, DuQuoin, Illinois
Piatt County: — Dr. W. N. Sievers, White Heath, Illinois
Pike County: Dr. James H. Rutledge, Pittsfield
Pope County:
Pulaski County: — Dr. Otis T. Hudson, Mounds, Illinois
Randolph: — Dr. W. W. Fullerton, Steeleville, Ill.
Richland County: — Dr. A. T. Telford, Historian, Olney
Send communications to: — Dr. Richard Birnbaum, Olney, (secretary)
Rock Island County: — Dr. Paul P. Youngberg, 1630 Fifth Avenue, Moline, Illinois
St. Clair County: — Dr. C. F. Leonard, 3004 Linden, East St. Louis, Illinois
Saline County:
Sangamon County: — Dr. Herman H. Cole, Myers, Bldg., Springfield
Schuyler County: — Dr. C. M. Fleming, Rushville, Illinois
Shelby County: — Dr. J. C. Westervelt, Shelbyville, Ill.
Stephenson County: — Dr. J. S. Clark, 507 2nd Natl. Bank Bldg., Freeport, Illinois
Tazewell County: — Dr. Sam. Glasford, Pekin, Illinois

(*Continued on page 208*)

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Emmet B. Bay, Edwin F. Baker, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Ford K. Hick, Edwin F. Hirsch, May McDonald Milligan, Marie Wessels, Walter M. Whitaker, Holland Williamson.



Pre-Marital Tests and Marriage Counseling

Physicians have accepted responsibility in so many fields of education involving preventive medicine that their responsibility in education for marriage should thererfore be unquestioned.

Since pre-marital examinations for venereal disease are required in Illinois for marriage licenses, both the man and woman must visit a doctor, clinic, or laboratory for tests. This visit affords the physician an excellent opportunity to offer pre-marital advice, particularly in sex education. If the blood and smear are taken by a technician or nurse, or if they are obtained in a hurried or routine manner, the opportunity for pre-marital education may be lost.

The suffering caused by destructive human relationships in general, and in marriage particularly, is probably as great as that caused by germs and physical malfunctions. The rising divorce rate, the number of broken homes, certain aspects of delinquency, the incidence of abortions, alcoholism, and many other appalling developments are terrifying evidence of maladjustments in either physical or emotional relationships. Psychiatrists and psychosomatic medicine testify to similar truths.

Examination for fitness is an accepted procedure for most occupations. But there is no law requiring that people prove their fitness for marriage and parenthood, perhaps the most important human relationships in our society. Examination for venereal disease before marriage is one important step in preventive medicine but physicians have further social responsibility in education for marriage. The family is the basic unit in our society. If the members of these units are personally well adjusted in most aspects of their relationship they will be an asset to any community, and to society in general.

Doctors, educators, the clergy, and social workers share the responsibility for expanding the field of education for marriage. Many colleges and universities do offer marriage courses. In these courses various aspects of marriage relationship are discussed, economic, social, religious, sexual, and individual attitudes. These obviously are important, for marriage can fail

because of personal maladjustment or character defects. Since, however, marriage is a friendship plus a sex relationship, it can also fail because of sex maladjustment. Unfortunately, the majority of those contemplating marriage do not have access to this help.

It is in education in the sex aspect of the marriage relationship that the physician can be most helpful. Every physician knows the frequency of failure of adjustment in the sex side of marriage. In most instances the maladjustment is due to ignorance, misinformation, clumsy techniques, conflicts, anxieties, or ill-advised contraception. In most instances, also, the tragedy lies in the fact that these difficulties could have been prevented.

The majority of young couples, men as well as women, enter marriage beset with fears and anxieties because of ignorance, taboos, inhibitions, and often guilty feelings regarding sex. For many reasons, economic, social, and health, they want knowledge concerning contraception. Of all human relationships, the sex relationship should be free from a fear component, whether it be fear of inadequacy, injury, guilt, or an unwanted pregnancy. The ideal preparation for marriage is sex education beginning in infancy; lacking this, competent pre-marital advice can avert many a broken life. To wait for advice and guidance until long after marriage, when the patterns of sex conduct are set and the inevitable tragedies like frigidity, impotency, and resentments are entrenched, is sheer neglect of the physician's responsibility.

Most young men and women who go to the doctor for pre-marital tests are eager for help. A hurried, impersonal, or repressed attitude on the part of the physician may discourage questions. Pre-marital couples who have understanding guidance — often in spite of early sex mis-education — enter marriage with a greater sense of security and freedom from most conflicts and fears. If at the pre-marital conference with their physician they have encountered an understanding attitude they will feel free to return should difficulties arise later in their marriage.

Obviously the physician's personal attitude toward sex will largely determine the success or failure of his counsel. Factual information about the physiology of sex relationship and contraception is important, but attitudes and understanding are more important. Unfortunately, emotional integration and proper sex attitude are not taught in most medical schools. If, because of disinterest, or personal conflict, the examining physician feels he cannot or does not wish to give such an interview he can at least accept responsibility by referring the patients to books and pamphlets on the subject, or by sending them to some other physician who is an expert in this field.

Pre-marital counsel will not solve all the ills of marriage but education in sex attitudes, factual information regarding sex relationship in marriage, and knowledge of contraception, will aid greatly in preventing many of the tragedies of sex unhappiness. In establishing the foundation for happier and more lasting marriages, the physician performs a service in the field of education and preventive medicine, and also makes a civic contribution toward the betterment of our society.—M. W.

VOLUNTARY HOSPITALS WORTHY OF SUPPORT

It should be agreed that the voluntary hospital, which concerns itself not only with the care of the sick but also with the training of personnel, the conduct of research and the prevention of disease, is worthy of the increasing and continuing support of everyone in the community who is in a position to give financial assistance.

From the point of view of the patient served, the medical profession should exercise good judgment in limiting admission to patients who are actually in need of "in-bed" care. To hospitalize a person because he is a member of Blue Cross, or even because he can afford to pay for service, is uneconomic, unsound, and particularly unwise in that it deprives someone in more urgent need of the opportunity for medical or surgical treatment.—*New England Journal of Medicine.*

STATE DEPARTMENT OF PUBLIC HEALTH



Disasters Without Disease

Tornadoes and floods which devastated several communities in Illinois during April focused public and professional attention on the importance of coordinating the efforts of private and public health agencies to minimize disease on such occasions.

To this end, the midwestern area of the American Red Cross sponsored a State Disaster Meeting in the Illinois State Armory in Springfield on April 28. Major General Leo M. Boyle, Adjutant General and Coordinator of the State's Emergency Disaster Plan, represented the several departments of Illinois state government in his speech, "Responsibilities and Resources of State Government in Time of Disaster."

This meeting was attended by the sheriffs, mayors, chiefs of police, fire chiefs, and other interested local officials. The purpose of the meeting was to learn about each other's job in order to assure more effective operation when disaster strikes. We all recognize and appreciate the great help which local physicians and the American Red Cross give in time of disaster. In the following account we shall point out only the disaster health services of your State Department of Public Health.

Local Public Health Departments. Among official public health organizations, the fulltime county or city health department, if one exists, constitutes the first line of defense against disease in a disaster. When there is no local health department; when the resources of the local department have been exhausted; or when it is foreseen that its resources are inadequate, requests for assistance are made to the State Department of Public Health in Springfield.

Health officers, public health nurses and sanitary engineers from local health departments promptly enter the area when disaster strikes. They appraise the public health problems and the need for service. They utilize their stocks of vaccines, serums, and blood plasma to prevent the spread of disease and to aid the injured.

State District Health Departments. The personnel of the fourteen District Health Offices of the State Department of Public Health also function in disaster areas where city and county health departments are lacking or where supple-

mentary service is needed. They serve large areas where there are no local health departments. The same on-the-spot services are given as are described above.

The Director of the State Department of Public Health is then promptly notified of: (1) the extent and nature of the disaster; (2) the imminent and anticipated needs for assistance from Springfield; (3) the need for additional physicians, nurses and sanitary engineers; (4) the sanitary conditions which require correction by personnel from the Springfield offices; (5) the need for additional serums, vaccines and blood plasma; (6) the need for informative pamphlets, posters, syringes or sanitation equipment; (7) the existence or threat of epidemics; and (8) the general health situation relative to safe water supplies and the disposal of human wastes.

Physicians. The local physicians, of course, are immediately on the spot in disasters to give aid to the injured and to immunize against disease. The personnel of local and State District Health Departments do all they can to help physicians in their fight against death and disease.

Nursing Services. The public health nurses from local and State District Health Departments rush to the disaster area as soon as possible and cooperate with the local Red Cross nurses in providing immediate nursing service. Public health nurses assist in first aid emergencies; they assist the physicians in caring for the injured; they get in touch with the hospitals in the area and offer their help; they assist in giving immunizations against disease; and they assist in getting more nurses into the area. The public health nurse, in her visits to homes in disaster areas, is able to check on medical needs, the care of babies and pregnant women, and the care of the sick.

Sanitation. The sanitary engineers of local and State District Health offices also enter the disaster area as soon as possible to help correct any unsanitary conditions. They appraise the situation from a sanitation view-point as to the need for additional engineers or equipment. They check public water supplies and assist local water plant operators in maintaining safe water. They condemn wells until they can be rendered safe for use by chlorination. They check the means for disposing human wastes to see that they are sanitary. If a dairy is involved in a disaster, they check the plant to insure the production of safe milk.

Drugs and Biologicals. Drugs and biologicals, which the State Health Department distributes free-of-charge to physicians and hospitals through its District Health Offices and through city and county health departments, prevent the spread of disease and infection during disasters. They are typhoid vaccine, tetanus antitoxin, diphtheria toxoid and antitoxin, and immune serum for measles.

In time of disaster when a community's water supply becomes impure, there is always danger that typhoid fever may develop. Even if the water supply is chlorinated, in many disasters it is important that citizens be immunized against typhoid fever as a double check on controlling this disease.

Another dangerous infection which is apt to develop in disasters is tetanus. Since the spores of this disease live in the soil, they are liable to enter wounds or cuts in the skin. Physicians usually find it necessary to give tetanus antitoxin to injured disaster victims.

Cases of communicable diseases are usually isolated in homes. When homes are destroyed or rendered uninhabitable, persons with communicable diseases are often brought in temporary contact with well persons. This is frequently true of measles. Protective serum against measles is supplied for children who need such protection. If diphtheria appears among the disaster victims, diphtheria antitoxin and toxoid are made available for protection and treatment.

Dried blood plasma, which has been collected by the American Red Cross, is available for distribution through the State Health Department. Plasma is furnished to hospitals, physicians and local health departments. In time of disaster, the prompt administration of plasma may save a life.

Know Your Health Officer. Physicians may consult with and seek assistance from Public Health Officers. Before disaster strikes, or regardless of disasters, it is well to learn the name of the Health Officer who serves your area. It will be to your mutual advantage to make his acquaintance if you have not done so already.

CORRESPONDENCE



GRADUATE COURSE IN ENDOCRINOLOGY

The American College of Physicians will sponsor a postgraduate course in endocrinology at the La Salle Hotel, Chicago, November 1-6. Tuition fee for members will be $30 and for non-members $60. Leading teachers from all over the country will take part in the course, of which Dr. Willard O. Thompson, Chicago, is Director. All applications to participate in this activity should be sent to Mr. E. R. Loveland, executive secretary, American College of Physicians, 4200 Pine Street, Philadelphia 4.

SILIFORM AMPULS POTENTIALLY DANGEROUS

Druggists and the medical profession were urged today by the Federal Security Agency's Food and Drug Administration to return all stocks of Siliform Ampuls to the manufacturer, The Heilkraft Medical Company, Boston, Mass. This injection drug, which should be sterile, is potentially dangerous since samples collected on the market contain living organisms. Siliform is injected by some physicians and osteopaths in the belief that it will relieve patients suffering with rheumatism as claimed by the manufacturer. The Food and Drug Administration found the contaminated samples after a routine inspection at the Heilkraft factory disclosed that the Siliform Ampuls had been manufactured without sterilization. Intensive recall efforts by the manufacturer and the Food and Drug Administration for the past two weeks have not brought in all of the contaminated stocks. The article, which moves slowly, was shipped to 37 states from Maine to California and later was redistributed by wholesalers who cannot trace many of their sales. Some going back as far as 1946 have been found on the market. These ampuls may be in the hands of doctors, hospitals, clinics, and retail and wholesale druggists.

CHEST PHYSICIANS ELECT OFFICERS

Dr. Minas Joannides, Chicago, Illinois, was elected treasurer of the American College of Chest Physicians at the 14th annual meeting of the College held in Chicago, June 17-20.

Dr. Robert K. Campbell, Springfield, Illinois, was re-elected chairman of the board of governors of the College and Dr. Paul H. Holinger, Chicago, Illinois, was appointed chairman of the committee on scientific program for the next annual meeting of the College.

The following physicians in Illinois were admitted to Fellowship in the College in the class of 1948 and received their Fellowship Certificates: Doctors Albert H. Andrews,

Chicago, Johann Bornstein, Chicago, J. Edmond Bryant, Evanston, E. J. DesAutels, Hines, Kenneth C. Johnston, Chicago, William S. Klein, Chicago, S. A. Levinson, Chicago, Saul A. Mackler, Chicago, Henry C. Sweany, Chicago, Italo F. Volini, Chicago, Clarence L. Wheaton, Chicago.

Fifty-two candidates took their oral and written examinations for Fellowship in the College on June 17, at the annual meeting.

INVITATION TO MICHIGAN'S ANNUAL MEETING

Doctors of medicine from Illinois are cordially invited to attend the 1948 Annual Session and Postgraduate Conference of the Michigan State Medical Society which will be help in Detroit at the Book-Cadillac Hotel September 22-23-24.

The program of scientific sessions in the fields of medicine and surgery will feature many of the outstanding physicians and surgeons in the United States. Among the 31 guest essayists are: F. H. Lahey, M.D., Boston, Mass., Waltman Walters, M.D., Rochester, Minn., R. W. TeLinde, M.D., Baltimore, Md., Haven Emerson, M.D., New York, N. Y., L. H. Dragstedt, M.D., Chicago, Ill., Alexander Brunschwig, M.D., New York, N. Y., and S. P. Reimann, M.D., Philadelphia, Pa.

To insure hotel accommodations for the Session write E. C. Texter, M.D., Chairman of Housing Committee, 1005 Stroh Bldg., Detroit, Michigan.

DIRECTOR FOR MENTAL HYGIENE SECTION SOUGHT

We would greatly appreciate your making an announcement in your various appropriate publications of the fact that there is a vacancy in the Chicago Department of Public Health for Director of its Mental Hygiene Section.

The Mental Hygiene Section will assume responsibility for developing and implementing a mental health educational program for the City. The position offers a real challenge and a great opportunity for pioneering work in the community mental hygiene program on a public health basis. The Board of Health is prepared to offer $10,000 per annum for this position.

Lewis J. Pollock, M. D.
Chairman, Advisory Committee
on Mental Health Program
Chicago Board of Health

NAVAL AIR RESERVES NEEDS DOCTORS

The Naval Air Reserve Training Command needs doctors. Doctors who served in the Navy during the past war and who still hold reserve commissions are requested to apply for two-weeks annual training duty or up to five months extended duty at Naval Air Stations, is was announced this week by Rear Admiral Richard F. Whitehead, USN, Chief of Naval Air Reserve Training.

Naval Reserve Medical Officers who can possibly spare the time, are urged to apply for this duty to help alleviate the work-load at those stations which are under-manned. Applications are made via the Commanding Officer of the Air Station to the Commandant of the Naval District concerned. The following Naval Air Stations need assistance: NAS Akron, NAS Atlanta, NAS Columbus, NAS Dallas, NAS Denver, NAS Glenview, NAS Grosse Ile, NAS Los Alamitos, NAS Memphis, NAS Miami, NAS Minneapolis, NAS New Orleans, NAS New York, NAS Oakland, NAS Olathe, NAS Squantum, NAS St. Louis, NAS Willow Grove, NAResTraUnit, Anacostia, D.C., NAResTraUnit, Jacksonville, NAResTraUnit, Norfolk, NAResTraUnit, Seattle, NAResTraUnit, Lakehurst.

ACTIVE DUTY BILLETS

The shortage of Medical Officers in the Naval Air Reserve Training Command has at all times been acute. In general, billets for two Medical Officers of the Naval Reserve of the rank of Comdr. and Lieut. are authorized (with privilege of waiver of rank) on full time active duty.

Medical Officers who request active duty for one year or more are eligible for additional pay of $100.00 per month over and above regular pay.

Officers qualified in aviation medicine are especially desired. However, Medical Officers on active duty can apply for the five-month course at the School of Aviation Medicine at Pensacola, Fla., eventually leading to the designation: Naval Flight Surgeon.

Quarters are available at some stations and Medical Officers in the Naval Air Reserve cannot be transferred without consent.

Naval Reserve Medical Officers who are desirous of this duty or wish to obtain further in-

formation should write to: Staff Medical Officer, Naval Air Reserve Training Command, Glenview, Illinois.

Woman's Auxiliary

PRESIDENT'S MESSAGE 1948-1949

The Woman's Auxiliary to the Illinois State Medical Society has entered into a new year with high aims and limitless possiblities for service to the medical profession and to the various communities. Our responsibilities are ever increasing; we must meet the challenge in order to bring to a successful finish the problems before us.

The Medical Society has this year assigned a major project for the Auxiliary to undertake. They have asked us to assume the responsibility of collecting biographical data concerning all deceased doctors and doctors who once practiced in the various counties, but have moved elsewhere. This information is to be used in compiling a history of the Medical Society in Illinois. As your President, I am asking that this activity be placed at the head of your program for the year. We must not, we will not, fail in this most important task. If we are successful in gathering the material needed we will be again honored by being asked by the Medical Society to help record the source of the material.

As in former years we must continue to be informed members in the fields of medical legislation and public relations. Our contribution to the benevolence fund has been a source of satisfaction and this year we hope to reach a higher figure than has ever been reached before. Active interest should be continued in health education, in its many phases. Hygeia plays an important part in many of the auxiliary activities and will always be one of its major concerns. An increase in membership should be stressed throughout the state. The auxiliary has had a steady growth since its beginning, yet much can be accomplished toward greater expansion of the organization.

Let us be faithful and loyal to our objectives and ideals. Through close cooperation we shall reach the heights of endeavor in our auxiliary undertakings. May the year be a successful and happy one for all of you. I pledge to you complete support at all times.

Mrs. L. N. Hamm, President

OFFICERS OF THE WOMAN'S AUXILIARY, 1948-1949

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President-Elect: Mrs. E. M. Egan, 6741 Euclid Ave., Chicago, Ill.

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PRINTING: Mrs. Carl F. Becker, Park Place, Lincoln, Ill.

PUBLIC RELATIONS: Mrs. Roy Hutchinson, 4418 W. Parker Ave., Chicago, Ill.

PROGRAM: Mrs. Carl E. Sibilsky, 100 N. Glenwood, Peoria, Ill.

REFERENCE: Mrs. G. Henry Mundt, 2214 E. 69th St., Chicago, Ill.

REVISIONS: Mrs. Warren W. Young, 10750 Calumet Ave., Chicago, Ill.

PARLIAMENTARIAN: Mrs. Clarence Goodwin, 4646 Woodlawn Ave., Chicago, Ill.

CHAIRMAN OF MEMBERS-AT-LARGE: Mrs. A. E. McCornack, 265 Hamilton Ave., Elgin, Ill.

FEVER THERAPY MAKES PENICILLIN MORE USEFUL AGAINST SYPHILIS

Artificially produce fever increases the effectiveness of the seven and a half day penicillin treatment for syphilis to more than 80 per cent, a substantial improvement over both penicillin alone and pencillin and mapharsen in combination for the same length of time.

This valuable use of fever therapy is described by Herman N. Bundesen, M.D., president of the Chicago Board of Health, and a group of four doctors who assisted him, in an article which appears in the July 31 issue of The Journal of the American Medical Association.

Three of the doctors — George X. Schwemlein, research associate at the Kettering Foundation for Medical Research, Cincinnati, Ohio; Theodore J. Bauer, senior surgeon of the United States Public Health Service and venereal disease control officer, Chicago, Ill., and Robert M. Craig of Dayton, Ohio — together with Dr. Bundesen, pioneered the penicillin and penicillin-mapharsen treatments for syphilis.

In comparison with the 80 per cent effectiveness of penicillin and fever therapy in seven and one half days their tests show penicillin 70 per cent effective and penicillin given with mapharsen, a compound of arsenic, 49 per cent effective against syphilis in seven and one half days.

The fourth physician in the research group is Jack Rodriquez, medical director of the Chicago Intensive Treatment Center, Chicago, Ill., where the group tested the fever and penicillin method from January 4 through July 29, 1945.

Each patient was given an injection of sodium penicillin every three hours for 60 doses, plus three 3 hour sessions of artificial fever on alternate days, beginning 23 hours after the penicillin was started.

Fever therapy, however, does not cut down on the time required for penicillin treatment, the doctors found. When they gave patients the same amount of penicillin — 1,200,000 units — in about 30 hours and reduced the fever therapy to one six-hour session, the treatment was effective in only about 60 per cent.

Neither is giving large amounts of penicillin without fever therapy more effective, the article indicates, citing research not yet completed. When patients were given 25,000,000 units of penicillin in 24 hours during this research, the drug was about 65 per cent effective.

In all, the doctors treated 120 patients under the penicillin-fever method, including 64 who were in the secondary stage of syphilis and nine whose blood tests did not show the disease. Eleven of the group did not finish treatment — eight because of lack of cooperation with the doctors, two because of cardiovascular fatigue during the period of fever therapy, and one because of uncontrollable fever. All syphilitic lesions healed immediately after treatment, although no more quickly than with penicillin alone, the doctors comment.

No serious reactions were noticed by the doctors. Sixty-four of the 100 patients whose blood tests were positive for syphilis achieved negative blood tests. In 16 of the 109 patients who completed the seven and a half days, the treatment failed — that is, their blood test were considered significantly positive by the doctors.

Two of these 16 had relapses of primary syphilis and five had relapses of secondary syphilis. In five the primary stage of the disease progressed to the secondary, and four who had achieved negative blood tests again had positive ones 12 months afterward.

ORIGINAL ARTICLES



Propyl Thiouracil in The Management of Complicated Hyperthyroidism

George M. Curtis, M.D., Arthur C. Connor, M.D. and Roy E. Swenson, M.D.
Columbus, Ohio

Clinical experience, leading to an evaluation of thiouracil and its allies has now been extensive. Numerous contributions have been made concerning their mode of action, the specific indications for their use in the treatment of hyperthyroidism as well as the clinical end-results obtained[1,2,3,4]. To date relatively less has been investigated and concluded concerning the newer and less toxic propyl thiouracil[3,4,5,6,7,8,9,10].

Interest in this latter goitrogen is greater because of its lower toxicity as well as the lesser amount required to produce metabolism-depressing effects. Moreover, the profession is becoming more informed concerning the therapeutic use of the various goitrogenic drugs.

At present propyl thiouracil is regarded as indicated in the management of certain groups of hyperthyroid patients. Its greatest advantage is found in the treatment of those who are regarded as poor surgical risks. This group (A) includes the severely toxic, the thyrocachetic, the aged, as well as those with disabling cardiovascular disease or with other serious concomitant illness[4,7,8,9]. Preparation with propyl thiouracil provides a sufficient length of time in which treatment, rest and recovery may take place before the indicated surgery. In those who do not improve sufficiently, continuation of propyl thiouracil medication is usually possible.

A second group (B) consists of those patients with hyperthyroidism recurring after previous surgery who for some reason actively refuse

From the Department of Research Surgery, the Ohio State University, Columbus, Ohio.

Presented before the Illinois State Medical Society at Chicago, May 12th, 1948. Aided by a Grant from The Mary Christie Curtis Fund for Surgical Research of The Ohio State University.

another thyroidectomy. Proponents of the use of propyl thiouracil for all cases of recurrent hyperthyroidism reason that further surgery should be withheld unless it becomes imperative owing to the increased risk of recurrent laryngeal nerve injury with resultant vocal cord paralysis or of parathyroid injury with resultant disabling hypoparathyroidism [7,8]. For this group propyl thiouracil provides a substitute form of long-term therapy.

A third group (C) consists of those for whom treatment with iodine is unsatisfactory because they are "refractory" to its usual administration or show hypersensitivity. For these patients propyl thiouracil may be used as a slower acting substitute.

The following patients are presented as representative of each of the three group indications adopted in our clinic for the preoperative use of propyi thiouracil. The first patient presented diffuse hyperplastic goiter with hyperthyroidism of long standing, complicated by severe cardiovascular disease with impending cardiac failure; the second presented recurrent nodular goiter with hyperthyroidism for which the patient refused surgery; and the third had diffuse hyperplastic goiter with hyperthyroidism complicated by an unusual sensitivity to iodine.

L.C. (No. 475414), a white housewife of 61 was admitted to the University Hospital on June 19, 1947. She complained of nervousness, dull headaches, exertional dyspnea, palpitation which was increased on exertion, recent weight loss, weakness and profuse sweating. About a year previously these symptoms had been severe enough to send her to her physician. Examination at that time disclosed a blood pressure of 190/100, pulse 110, a negative urine and a basal metabolic rate of plus 25. Initially there had been a notably good response to medical management which consisted of lugolization, digitalis and the use of sedatives. During the past month, however, her condition had grown progressively worse.

Physical examination on entrance revealed a temperature of 98.6, a pulse of 120, respirations 20 and a blood pressure of 140/80, all measured under basal conditions. She was a thin, elderly woman with a worried look and an obvious tremor. She was dyspneic. Her thyroid was diffusely and evenly enlarged. There was lobulation but no definitely palpable nodules. Her heart revealed no evidence of valvular lesion yet presented a moderate enlargment; a loud, functional, apical systolic murmur and an occasional extrasystole. The lungs were clear. The liver was palpable and tender and there was a mild pre-tibial edema. In addition there was also moderate arteriosclerosis.

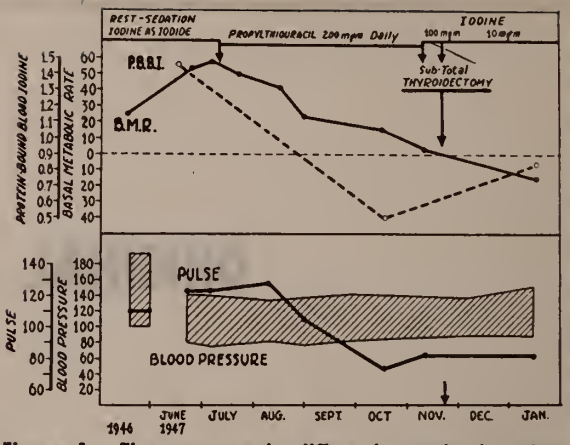


Figure 1. The response in diffuse hyperplastic goiter with hyperthyroidism complicated by congestive heart failure.

Laboratory examination revealed a basal metabolic rate of plus 51. The protein-bound blood iodine was 1.44 mcg. per cent, which is definitely elevated over normal. No casts or red blood cells were seen on urinalysis. An EKG revealed a sinus tachycardia and evidence of myocardial damage. The RBC were 4.22, the hemoglobin 13.4 and the WBC 6000. The differential count revealed 56 per cent neutrophils, 42 per cent lymphocytes and 2 per cent eosinophil cells.

Initially, the patient was placed on 100 mgm. of iodine daily, administered as potassium iodide; together with 600 mgm. calcium, 400 mgm. phosphorus and 2,500 units of vitamin D daily, supplied as four Calirad Wafers.* A high protein, high caloric low fat diet was provided. In addition, a regimen of rest together with adequate sedation was maintained. Nevertheless, after three weeks of management she had not improved sufficiently to permit thyroidectomy without what was regarded as a definitely increased risk. Consequently, the more time-consuming preoperative preparation with propyl thiouracil was instituted.

Beginning July 10, 200 mgm. daily of "Probacil"† were given (50 mg. q.i.d.). The BMR fell from plus 58 on July 7 to plus 6 on November 6, which is at the rate of 0.43 units per day. The protein-bound blood iodine decreased from 1.44 mcg.% to 0.50 mcg.%, which is well below the normal range (Figure 1). The patient definitely improved. Her anxious look and dyspnea disappeared; the tremor and increased perspiration decreased; the pulse became regular and declined to an average 82. The apical systolic murmur gradually disappeared. The pre-tibial edema subsided and the liver was no longer palpable or tender.

During September a transitory granulocytopenia was observed. This was asymptomatic and disappeared within two weeks without any alteration in the therapy. The lowest count obtained was one of 2700 leucocytes,

*The Winthrop Chemical Company kindly supplied these for our clinical studies.

†The Lederle Company kindly supplied this for our clinical studies.

with 864 granulocytes, 1728 lymphocytes and 88 monocytes.

During September and October it was noted that her goiter had increased moderately in size and had developed an audible bruit and palpable thrill. On November 6, propyl thiouracil was discontinued and she was given 100 mgm. of iodine as potassium iodide daily, together with 600 mgm. calcium, 400 mgm. phosphorus and 2500 units of vitamin D in the form of four Calirad Wafers, daily.

On November 25, a subtotal thyroidectomy was accomplished without incident. Nevertheless, her goiter was quite vascular and there was considerably more oozing than is ordinarily encountered after our usual method of preparation. Moreover, the gland was softer and more friable. Ninety-eight grams of thyroid tissue were removed. This was largely diffusely hyperplastic; however, revealed some well advanced nodule formation. Microscopic sections showed a well involuted gland with moderate residual hyperplasia and evidence of early nodule formation.

The postoperative course was uneventful and she remained for six weeks on 10 mgm. of iodine daily, given as an "oridine" tablet. During this period she noted a progressive decrease in her nervousness and improved steadily. She experienced dyspnea and palpitation only after climbing stairs. Six weeks postoperative, January 15, her temperature was 97.6, pulse 71, respirations 17, blood pressure 140/80 and BMR minus 18. The protein-bound blood iodine was 0.84 mcg. per cent which is average normal. No residual tremor was observed. The operative site was well healed. Her pulse was regular. The heart was still slightly enlarged but revealed no murmur. She appeared greatly improved.

Thus is presented an example of the first (A) of our group indications for the use of propyl thiouracil in the treatment of complicated hyperthyroidism. Our usual more rapid preoperative preparation; using iodine; calcium, phosporus and vitamin D was not sufficient adequately to prepare this patient for a safe thyroidectomy. Moreover, her cardiovascular system needed added time for rest and recuperation. These were made possible by the administration of propyl thiouracil. Some years ago, before the advent of the goitrogens, this patient would ordinarily have been treated by some temporizing procedure such as superior pole ligation, hemithyroidectomy or even by radiation therapy. Later, and when she was regarded as adequately prepared, the thyroidectomy would have been completed. In the management of these complicated cases propyl thiouracil now gives us a simpler, safer and more certain control of the hyperthyroidism preparatory to the eventual thyroidectomy.

The second patient illustrates the expedient use of propyl thiouracil in the medical management of recurrent nodular goiter with hyperthyroidism complicated by arteriosclerotic heart disease and a psychological inbalance with the refusal of further surgery.

A.T. (K.H. Clinic), a white man of 57 was first seen on June 3, 1947. He complained of frequent angina of about a year's duration, as well as nervousness, vertigo, palpitation and headache of about two months' duration. Before this he had a fairly extensive surgical history starting with a submucous resection in 1933, a T and A in 1934, a herniorrhaphy in 1938 and ending with a two-stage thyroidectomy, elsewhere in 1946. Before the thyroidectomy his BMR had reached plus 52. This had never returned to normal postoperatively; the lowest of several postoperative determinations was plus 26.

The patient was small, tense, and thin. He blinked his eyes frequently, held his lips tightly pursed and stammered whenever he started to speak. In addition, he never quite seemed willing to accept the fact that he was ill and should have further treatment. Examination revealed a normal temperature, a pulse of 96, a respiratory rate of 20 and a blood pressure of 130/70, all measured under basal conditions. There was marked tremor. There was a palpable nodule of the anterior margin of the left lobe. Moderate arteriosclerosis was seen in the fundi and felt in the peripheral arteries. The heart was normal to physical examination. The lungs were clear, the prostate gland was tender due to a chronic prostatitis. The legs showed no edema.

Laboratory examination revealed a BMR of plus 26. The protein-bound blood iodine was increased to 2.28 mcg. per cent (normal values range from 0.7 to 1.1 mcg. per cent). A few leucocytes were found in the urine. An electrocardiogram was normal.

Initially the patient was placed on iodine; calcium, phosphorus and vitamin D medication. This was supplied as 20 drops of Lugol's solution and four Calirad Wafers daily. This totals 150 mgm. iodine, 600 mgm. calcium, 400 mgm. phosphorus and 2500 units of vitamin D. He was instructed to take a high protein, high caloric and low fat diet. In addition he was advised a regimen of reduced activity and given mild sedation. The BMR fell to plus 19 in two weeks and the protein-bound blood iodine to 1.02 mcg. per cent, with a subsequent decline of the BMR to plus 6 during the next two weeks (Figure 2).

Despite the excellent reponse of his hyperthyroidism to our usual preoperative preparation he noted but little symptomatic improvement. It was concluded that the status of his cardiovascular system did not make surgery advisable at that time. In addition, the patient made it clear that he was firmly opposed to further surgery. Consequently, medical management was undertaken and he was placed on propyl thiouracil June 20, 1947.

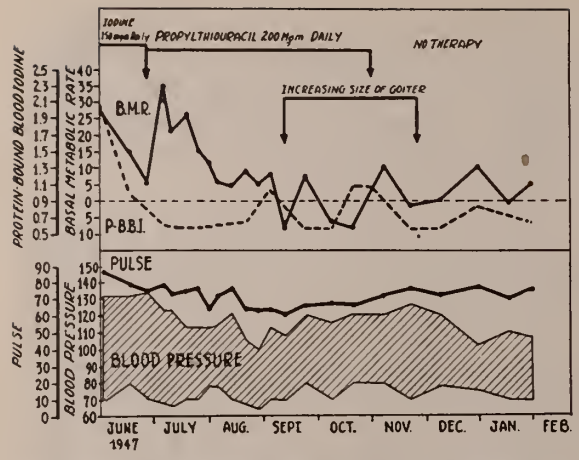


Figure 2. The response in recurrent nodular goiter complicated by arteriosclerotic heart disease. The patient refused further surgery.

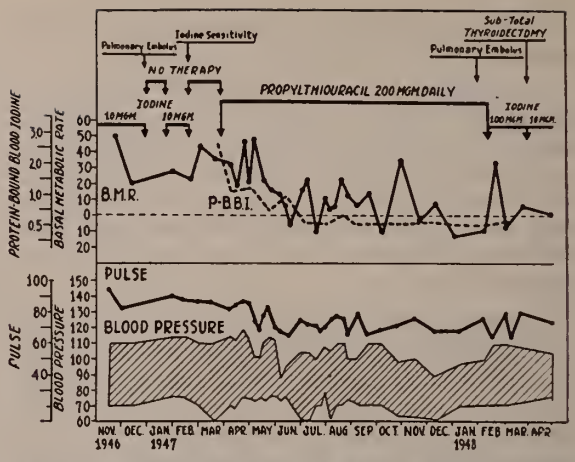


Figure 3. The response in diffuse hyperplastic goiter with hyperthyroidism complicated by unusual iodine sensitivity (iodism).

Under propyl thiouracil (50 mgm. q.i.d.) together with phenobarbital his symptoms improverd rapidly. There was an initial rise of the BMR, yet the protein-bound blood iodine remained low. Enlargement of the nodule in the anterior portion of the remaining left lobe was noted in September. In October a death in his family brought about a return of his angina, palpitation, dyspnea, headache and nervousness. However, this was accompanied by no return of his tremor, no rise of the BMR nor of the protein-bound blood iodine.

In November he attributed the return of his symptoms to the propyl thiouracil and discontinued it of his own accord. No change was noted. Three months later he began to note "spots before his eyes" which became increasingly disturbing to him. These were caused by opacities in the vitreous. No abnormality other than moderate arteriosclerosis was noted in the fundus. The etiology of his scotomata has remained obscure. It was not regarded as due to any medication. Thiouracil, a closely related drug, is largely excreted in less than 48 hours (11). During the subsequent three months without medication the BMR remained within normal limits, as well as the protein-bound blood iodine. He was regarded as in a period of prolonged remission. The patient's course to date is displayed graphically in Figure 2.

This history demonstrates three facts of clinical significance. *First,* the protein-bound blood iodine is a more reliable index of thyroid activity than the BMR (12). In this instance it enabled differentiation of his hyperthyroidism from the hypermetabolism traceable to his unstable emotions. He was disturbed about the prospect of further surgery when first treated in the clinic. This caused the rise in his BMR during July and August. Later rises correlated well with the frequency and severity of his angina. It is to be noted in Figure 2 that the protein-bound blood iodine did not rise beyond its normal range during these periods.

Second, changes in the level of the protein-bound blood iodine usually precede similar changes in the basal metabolic rate (see other accompanying figures). That is, the protein-bound blood iodine appears to be more of a moment to moment report on the state of the patient's thyroid activity, whereas the BMR tends to lag and be a delayed report. This information permits the surgeon to know at an earlier date that his hyperthyroid patient is ready for thyroidectomy. But what is more important is that a sharp rise in the protein-bound blood iodine occurring during preoperative lugolization may prove to be significant. Despite the fact that the BMR might still be falling, the patient is breaking away from iodine control and the BMR will rise shortly. This might detract from the chances of a smooth postoperative recovery.

Third, recurrent hyperthyroidism may be controlled by propyl thiouracil despite the handicap of concomitant organic disease and psychological imbalance. The usual rapid preparation with iodine; calcium, phosphorous and vitamin D was sufficient to bring this patient's hyperthyroidism under control. However, what was needed was some means of controlling the hyperthyroidism over a long period of time. Propyl thiouracil was used and has produced a prolonged remission.

The third patient illustrates the use of propyl thiouracil in the surgical preparation of primary hyperthyroidism complicated by an unusual sensitivity to iodine (Figure 3).

E.M. (No. 482582), a white assistant manager of 44 was first seen at the clinic on December 3, 1946. He complained of nervousness and tremor of several years' duration. Six months previously he developed a diarrhea during which he noted the onset of dyspnea, palpitation on exertion and an increase in his nervousness and tremor. On August 27, 1946 he had a hemorrhoidectomy. His convalescence was interrupted by a virus pneumonia and the development of thrombophlebitis of the right leg. This was followed by considerable increase of his nervousness, tremor, dyspnea and palpitation. In November his BMR was plus 50.

Physical examination revealed a temperature of 98.2, a pulse of 95, respirations 17 and a blood pressure of 110/70, all measured under basal conditions. The patient was a well developed, vigorous man with a ruddy complexion, and appeared younger than his years. His tremor was so extreme that it interfered with his actions. He was alert, intelligent and very cooperative but also extremely apprehensive. Exophthalmometry readings were 17 mm. bitlaterally, which is within normal limits. The thyroid was diffusely enlarged to about three times normal size, the right lobe being larger than the left. No nodules were palpable. The heart and lungs presented no physical abnormality. His right thigh was 1.5 inches greater in circumference than his left, and his right calf 1 inch greater. No tenderness was noted in Scarpa's triangle and Homan's sign was negative.

Laboratory examination revealed 5,130,000 RBC, a hemoglobin of 13.8 and a total leucocyte count of 6,350; 70 per cent being polymorphonuclear leucocytes. The BMR was plus 51 and the initial protein-bound blood iodine was 3.72 mcg. per cent which is greatly elevated, the normal limits being between 0.7 and 1.1 mcg. per cent. The urine revealed no abnormalities.

Initially he was placed on 10 mgm. of iodine daily in the form of "oridine" and 300 mgm. of calcium, 200 mgm. of phosphorus and 1250 units of vitamin D as two Calirad Wafers daily. He improved rapidly on this regimen. However, on December 31 he experienced an embolus with resultant left lung infarction for which he was hospitalized and treated by his family physician. He was referred back to the clinic on January 23, 1947. There was no indication of recurrence of his right femoral thrombosis. Therapy of his hyperthyroidism had been discontinued, consequently his symptoms had increased in severity. Iodinization was reinstituted. However, on February 15, 1947 the patient developed an extensive maculopapular eruption over the face and neck. This was accompanied by conjunctival injection and rhinorrhea, together with burning of the eyes, lacrimation and some photophobia. In addition he developed a diarrhea. These symptoms all subsided and gradually disappeared within two weeks after the iodine (10 mgm. daily) was discontinued.

Upon cessation of iodine medication the patient's tremor, nervousness, dyspnea and palpitation again increased. Consequently, it was concluded that the treatment of choice was propyl thiouracil and on March 29 this was begun. He was maintained on 200 mgm. per day (50 mgm. q.i.d.). The BMR fell from a level of plus 33 on March 15 to a minus 6 on June 20th. This is at a rate of about 0.43 units per day. The protein-bound blood iodine declined from 3.72 mcg. per cent to 0.50 mcg. per cent. During this period his symptoms subsided and he felt quite well. No depression of his white count was observed and there were no allergic reactions to the propyl thiouracil. January 27, 1948 he experienced another small pulmonary embolus. This das not as severe and required no hospitalization. There was no evidence of reactivation of his femoral thrombophlebitis.

February 12, propyl thiouracil was discontinued and he was placed on 100 mgm. of iodine, 300 mgm. of calcium, 200 mgm. of phosphorus and 1250 units of vitamin D daily. This time no sensitivity to iodine was noted. He was admitted to the University Hospital March 8 for thyroidectomy, however, developed an upper respiratory infection and surgery was postponed until April 1.

Thyroidectomy was accomplished uneventfully. The gland was soft, friable and unusually vascular. The goiter removed weighed 42 grams. There was diffuse enlargement. The right lobe was a little larger than the left. No nodules were present. Microscopic section showed well involuted alveoli, with moderate evidence of residual hyperplasia. His postoperative course was entirely uneventful. He has been maintained on 10 mgm. of iodine daily since, without any evidence of further iodism.

Four weeks postoperatively he revealed no nervousness, nor dyspnea and palpitation on exertion. There was no residual tremor. His temperature was 97.4, pulse 74, respirations 8 and blood pressure 104/76 under basal conditions. The BMR was plus 1. His incision healed well. His entire course is displayed graphically in Figure 3.

This illustrates the use of propyl thiouracil in severe primary hyperthyroidism complicated by an unusual sensitivity to iodine (iodism). Due to his threatening response iodine could not be used with security and propyl thiouracil provided an alternate form of therapy. It is interesting to note, however, that when iodine was eventually used to involute the gland preoperatively, no sensitivity reappeared.

This presents again the value of the protein-bound blood iodine in differentiating hyperthyroidism from hypermetabolism. The protein-bound blood iodine better mirrors the clinical picture and follows the general trend of the entire curve of the basal metabolic rates. The protein-bound blood iodine does not correspond

with the sporadic peaks in the basal metabolic rate which would appear to be, in reality, determinations of hypermetabolism in an apprehensive individual. This illustrates the value of propyl thiouracil as an alternate to the usual preoperative preparation of patients with hyperthyroidism.

Three cases of hyperthyroidism have been presented. Each is representative of one of the three group indications adopted in our clinic for the preoperative use of propyl thiouracil. Our first case presented diffuse hyperplastic goiter complicated by impending cardiac failure; the second, recurrent hyperthyroidism in which the patient refused surgical methods, and the third, a primary hyperthyroidism the management of which was complicated by iodine sensitivity. Each is illustrative of an indication for the use of propyl thiouracil. In the first patient, complicated by impending cardiac failure it provided the long time-interval of control during which the cardiovascular system recovered to the point that surgery could be performed without undue risk. For the patient who refused surgery it provided a remission of his hyperthyroidism. In the third case, complicated by an unusual sensitivity to iodine it provided an alternate form of preoperative therapy.

We are of the opinion that propyl thiouracil as used with judgment in the management of these three groups of patients provides an important adjunct in the treatment of hyperthyroidism.

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DISCUSSION

Frank H. Lahey, M.D., Boston, Massachusetts: Dr. Curtis's work with thyroid disease has paralleled ours and has been so sound that I could not disagree or be able to add anything to this excellent demonstration of the fundamental principles involved in managing thyroid disease. It was excellent for him to present to you the basic factors which give you a clear conception of some of the new principles and make it possible for you not to go off on a tangent with some of them.

I particularly wish to bring to you another method which has not been published but which is very useful in connection with interpreting some of the elevated metabolic rates which are so obviously false ones. Studies on protein bound iodine, in Dr. Curtis's laboratory or in any laboratory such as he and we conduct for investigative purposes, are excellent but they are time-consuming and expensive, and for you who do not have a blood iodine study laboratory it is valuable to have another method by which you can correct these dubiously elevated metabolic rates. Dr. Bartels, of our medical department, has found in patients with a known normal metabolic rate that he can give them pentothal and not change their metabolism. In the apprehensive patient who is badly adjusted to the test and in whom almost invariably there will be a falsely elevated metabolic rate, this method is valuable. They can be put to sleep to overcome these features. If they have hyperthyroidism their basal rates will remain elevated; if they do not have hyperthyroidism and their rates are falsely elevated, they will come to normal under the sleep produced by pentothal. I present this to you as another method of testing the patient in whom you believe the metabolism is not a true elevation from hyperthyroidism. Because pentothal requires precautions regarding laryngeal spasm I suggest you do not employ the method until you have read the article and can employ the necessary precautions against this complication.

The Surgical Aspects Of Placenta Previa

Frederick H. Falls, M.D.

Professor of Obstetrics and Gynecology and Head of Department, University of Illinois College of Medicine

Chicago

In considering the surgical aspects of any subject in medicine one must logically begin with the surgical anatomy. The surgical anatomy in placenta previa varies with the type of placenta previa in the patient under consideration. We may possibly best understand the condition if we review the pathogenesis of placenta previa.

The ovum entering the uterine cavity through the uterine end of the tube finds itself in the blastodermic vesicle stage of development and seeking entry into the decidua vera as it is carried downward toward the internal os of the cervic uteri. If it attaches a few centimeters above this point and the development of the placenta begins, the lower margin of the fully developed placenta will reach nearly to the internal os (placenta previa marginalis). If it implants within a centimeter of the internal os it will spread to involve the os (placenta previa lateralis), whereas if it implants at the internal os it will expand to occupy both sides of the uterus and give rise to a central placenta previa. From the point of implantation villi invade the decidua in the form of chorion frondosum and fastening villi extend to the muscularis of the uterus, in these cases the lower uterine segment.

It is necessary in this connection to remember the physiological role played by this portion of the uterine muscle wall during late pregnancy and labor. As pregnancy advances the lower uterine segment becomes thinner and stretches out to accommodate the growing fetus and in most cases the largest part of the fetus, the head. During labor it stretches still further. It has very little contractible power but acts as a passive passage way for the expulsion of the fetus by the dynamic contractile upper uterine segment.

Another most important consideration to be taken into account is the tremendous increase in vascularity of that part of the lower uterine segment involved by the placental site. This gives rise to a softness and suculence of the thinned out muscle tissue which interferes seriously with its contractile power which even under normal conditions are deficient because of the mentioned thinning and stretching.

Another important consideration is the position of the uterine artery and its branches in relation to the lower uterine segment. The main artery approaches the uterus from the side through the cardinal ligament at the level of the internal os of the cervix. When it reaches the side wall of the uterus it turns sharply upward practically on the surface of the lower uterine segment and between the leaves of the broad ligaments. In addition the cervical branch of the uterine artery also enters the cervix at about the same level and it too may be damaged by deep lacerations of the cervix. It will be seen therefore that a tear in the lower uterine segment in this type of case is fraught with special danger of hemorrhage because of these anatomical considerations. Antepartum hemorrhage is due usually to separation of the lower part of the placenta or to tears attendant upon injudicious attempts at manual dilatation of the cervix or delivery of the fetus forcibly by version or forceps before complete dilatation of the cervix. Postpartum hemorrhage may be secondary to cervical and lower uterine segment lacerations or to uterine atony especially prone to occur at the placental site for the above mentioned reasons.

Presented before the Section on Obstetrics and Gynecology, 107th annual meeting of the Illinois State Medical Society, May 12-14, 1947.

These considerations plus the accessibility of the placental site in the lower uterine segment to infective organism present in the vagine before the bleeding began or introduced from without by unsterile technique on the part of the attendants constitute the chief dangers in the management of this complication of pregnancy.

What then shall we do when faced with the problem of placenta previa as regards its obstetrical surgical management? Since the chief danger is hemorrhage three fundamental questions must be settled.

1. What type of placenta previa is present?
2. How much blood has the patient lost?
3. How much blood has the patient left?

Of secondary importance may be asked

1. The duration of pregnancy.
2. Is the patient in labor and if first or second stage?
3. Is the fetus alive and viable.

The diagnosis of the placenta previa is relatively simple. Painless causeless bleeding in the third trimester, should be considered placenta previa until proven to be from some other cause. The type can be determined by careful vaginal examination in the majority of cases without danger to the mother. I do not share the apprehension voiced by Dr. Irving of Harvard some years ago in a paper before the Chicago Gynecological Society that no patient should be so examined until she had been brought to the operating room, was on the operating table all scrubbed for delivery by cesarean section if profuse and uncontrollable hemorrhage was initiated by the vaginal or rectal examination. We have repeatedly done one sterile vaginal examination on such patients to determine the presence or absence of placental tissue over the cervical os as well as the thickness, firmness and amount of dilatation of the cervix. This is important information and should be obtained by the most experienced man in attendance on the case for on it may depend the method of procedure and incidentally the safety of the mother and baby. If the cervix is soft, dilated two or three centimeters and the placenta cannot be felt over the internal os, rupture of the bag of waters is all that is required in most cases to stimulate pains and allow the presenting part to come down and compress the separated part of the placenta against the lower uterine segment and control the hemorrhage, at least until the baby is born.

A similar result can be obtained in these cases by rupturing the membranes and introducing a No. 6 Voorhees bag into the amniotic cavity. With the expulsion of the bag about nine centimeters dilatation will be present which should permit the delivery of the small baby so frequently found in cases showing this complication. If the cervix is dilated at the time the bleeding occurs rupture of the membranes is usually all that is necessary to stop the bleeding. If it does not stop forceps may be applied and the baby delivered if the head is well engaged or version and extraction if the head is floating.

The Braxton Hicks version is a useful procedure in cases with little or no dilatation and under circumstances where cesarean section is contraindicated. In this procedure two fingers are inserted through the internal os, the baby turned by combined version, and a foot grasped and brought down to the knee or thigh. The case is then left to nature to deliver since extraction forcibly performed would result in serious lacerations in the vulnerable lower uterine segment and cervix and might result in uncontrollable hemorrhage postpartum. There is an inherent weakness in this method of delivery as well as in the use of the Voorhees bag. The insertion of the cord into the placenta may be in that part of the placenta that is compressed by the fetal thigh or the bag. In this case circulation in the cord would be cut off and the baby would die. Cesarean section therefore must be seriously considered when placenta previa of the lateralis or centralis type is considered.

The principle advantage of this procedure is the relative safety of the baby and therefore it is important to estimate accurately the maturity of the baby and its general condition before operation. It is important, as pointed out by Dr. Greenhill in 1920, to recognize the fact that placenta previa is not infrequently associated with malformation to the fetus, for this reason x-ray should be taken on all cases to determine whether monstrosity or deformity exists before doing a cesarean section. Since in most cases if the life of the fetus could be disregarded delivery from below would be much more seriously considered than if a normal viable fetus were present in the uterus.

The choice of the low cervical or classical cesarean section in these cases has given rise

to considerable controversy. My experience has led me to believe that very little difference is to be expected in the use of the two operations. If a classical operation is done one avoids the placental site which may reduce slightly the bleeding at the place of incision. In case bleeding is encountered after the delivery of the baby a ten yard uterine pack should be available and placed in the lower uterine segment to control this bleeding. More recently we have been experimenting with the use of Gelfoam in the control of bleeding from this source but it is too early to determine its value as yet.

If the low cervical cesarean section is done the bleeding points at the placental site can be controlled by clamps and sutures if necessary, but in the great majority of cases this is entirely unnecessary. An intrauterine pack can also be used in this incision and the uterus closed over the pack. The pack is removed vaginally in 24 hours. Because of the prematurity of the infant in so many cases it is important that preparation be made for the resuscitation of a small baby. A small flexible tracheal catheter should be provided and the resuscitation should be carried out in a foot bath of warm water to avoid heat loss. Oxygen should be available to aid in the resuscitation. The anesthetic may be local if the patient has lost much blood or general if not. Following severe hemorrhage oxygen should be supplied to the mother to reduce intrauterine fetal asphyxia while preparing for operation and during operation. If general anesthesia is advisable cyclopropane is the anesthesia of choice because of its high oxygen admxiture.

Postoperatively these patients should be watched for postpartum hemorrhage, and ergot and pituitrin given to help contract the uterus. Too much reliance should not be placed on the efficacy of these drugs since their action on the abnormal lower uterine segment cannot be expected to be highly effective. For this reason if hemorrhage persists after their use we do not hesitate to place the patient in lithotomy position, prepare the patient as for vaginal operation and insert a uterine pack through the cervix and make counter-pressure by packing the upper vagina.

At the first symptom of a placenta previa it is important to determine four things: the number of red cells, the amount of hemoglobin, the blood type and the Rh factor. The second important step is to locate compatible blood that is Wassermann negative whether this be obtained from a bank or donors. If there has been more than 200 cc blood loss, arrangements should be made for replacement by blood, plasma or salt solution before delivery procedures are instituted.

In cases of severe antepartum hemorrhage blood can be administered in both legs or both arms during operation. The amount necessary varies with the blood picture and clinical condition of the patient. Where blood is not available or pending its arrival, lower the head of the bed, binding the lower extremities, hot coffee enema and digitalis may support and reduce the shock while preparation is being made for delivery. All of these patients should be removed to a hospital as soon as a diagnosis is made or strongly suspected since there is no way of knowing when the fatal hemorrhage may occur. When removed to a hospital, consultation should be obtained before the patient has developed such severe anemia that whatever method of delivery is adopted may be too much for her resistance. Every ounce of blood that can be saved is valuable and may mean the difference between success and failure in the management of a case.

Surgical procedures are certainly not the only ones to be considered in connection with the management of placenta previa. However, they may be potentially part of the management of any case. It therefore is necessary to make preparations for these possibilities so that valuable time may not be lost when their need becomes apparent in a given case. Furthermore, the surgical possibilities of a case should be considered as early as possible in its management and either accepted or rejected on the basis of the conditions present. Delay and medical mismanagement should not be permitted in the early stages of the care of placenta previa and surgical intervention postponed as the last result and applied only when the condition of the patient is so desperate that the wisdom of any type of operation can be seriously questioned.

We have had at the Research and Educational Hospital since 1925 to the present time 66 cases of placenta previa in which we have done cesarean sections on 31 of which 20 were low cervical and 10 classical, and one Porro cesarean

Section. Version and extraction was done on 5 cases, breech extraction on 1 and version without extraction on 1. Spontaneous delivery occurred in 23, bag induction was used to combat hemorrhage in 4, low forceps 1, and breech in another. There were 53 multiparas and 13 primiparas. There was an average blood loss of 460 cc. The average length of gestation was 9 lunar months. There were 12 fetal deaths and 2 stillbirths, a total mortality of 21 per cent. Two sets of twins occurred, one pair lived and the other pair died. Only one baby was at term and none of the rest were over 34 weeks, 2 were non-viable. There were no maternal deaths.

DISCUSSION

Dr. Garwood C. Richardson, Chicago: Those of us who teach obstetrics certainly cannot help but be aware of the fact that this is a very large subject, and all the conditions that must be met in dealing with these cases cannot be discussed in the short period of time alloted to me.

In a general way I am quite in accord with Dr. Falls' handling of the subject. As to vaginal examination, I wish to say that we try to avoid such examination though occasionally it may be necessary. It is possible to tell by rectal examination that we are dealing with an extra amount of tissue between the examining finger and the presenting part of the fetus, except, of course, where there is a breech presentation and you are palpating against a soft buttocks. In that respect I wish to come to the defense of a procedure presented some years ago by Udey and Urner, of instilling into the bladder sodium iodide solution in order to diagnose placenta previa. The criticism of their work is that they stood steadfast on the grounds that you needed only a postero-anterior view to arrive at a diagnosis. We have run quite a large series of those cases and found them quite valuable in cephalic presentation. In some breech presentations we took as many as five exposures. We take both lateral and postero-anterior views to demonstrate the location of the placenta. Also, we have today a soft tissue technic in x-ray whereby the placenta may be identified by x-ray. In some instances that may obviate the necessity of doing a vaginal examination. I do not feel that vaginal examination is entirely without danger. I have personally encountered a number of cases where it was attended with quite severe hemorrhage in spite of the gentleness with which the examination was made.

Dr. Falls spoke of painless, causeless bleeding as being identical with placenta previa unless proved otherwise. I believe he has in mind those few cases of ablatio placenta where there is an escape of blood and occasionally a painless partial separation of the placenta.

In his discussion of cesarean section, Dr. Falls said that cesarean section is preferably done under local anesthesia where the loss of blood is great. In his paper that statement is supplemented with the recommendation that where general anesthesia is advisable, cyclopropane is the anesthesia of choice because of the high percentage of oxygen that is administered with it. At Wesley Hospital we have had considerable experience with the use of cyclopropane in general deliveries and also in cesarean section and other deliveries for placenta previa. The percentage of oxygen in cyclopropane is greater than in any other inhalation anesthesia. It is so great that where we have an embarrassed respiration from placenta previa or other causes and we do not get the cry for a few minutes, we find benefit is derived by the baby from the percentage of oxygen that it can absorb through the maternal blood in those cases where cyclopropane is administered. We have published a report of 1392 cases of cyclopropane anesthesia in obstetrics — now the number of cases has passed the 6,000 mark. We like it very much for all purposes as well as for use with placenta previa cases.

In his closing remarks Dr. Falls mentioned placenta previa and cesarean section and the site of the incision. Personally I like to feel out laterally to both sides when my incision comes down on the placenta and see if it is not possible to identify the margin of the placenta through the thickness of the uterus and then stretch the hand in between the placenta and the anterior wall of the uterus and quickly rupture the membranes and deliver the baby by podalic version instead of the usual method of delivery by forceps application to the head.

I am rather surprised at the small total number of placental previa cases that Dr. Falls reported from the Research and Educational Hospital since 1925. I just reviewed a nine months' statistical report by one of our residents at Wesley Hospital, and he reported 23 cases of hemorrhage due to placenta previa. I am sure that in the slightly over 7,000 cases that we have delivered in the new hospital we have had a somewhat larger number than the 66 reported by Dr. Falls, and certainly there were more deliveries in the Research and Educational Hospital than we had at Wesley. The figures I just quoted from Wesley do not include ablatio placenta. All our cases were verified cases either by feeling the uterus internally or by examining it visually at Cesarean section.

Progress In Cancer

Herman L. Kretschmer, M.D., D.Sc.
Chicago

The problem of cancer is everybody's problem. It is widespread in its distribution—occurring in man, animal and plant. Today we realize that cancer is not confined to human beings but is found in most multicellular organisms. It has been demonstrated that much can be learned from plant tumors, spontaneous tumors in horses, dogs, fish, turtles, frogs and mice.

Twenty-five years ago cancer stood seventh in the list of causes of death. Today cancer is the second major cause of death. In 1946, 184,000 persons in the United States died of cancer. Hektoen[1] has made the statement that if all accessible cancers were treated early by surgery or radiation, or both, 50.000 lives could be saved yearly.

Dargeon[2] stated that cancer, leukemia, and other tumors, in the last decade, have exceeded almost all common diseases among the causes of death in certain age groups during childhood.

There are several reasons for this progressive increase in the number of reported deaths from cancer.

1. As a result of the increase in the span of life more individuals reach the age groups when cancer occurs.
2. With our present accurate methods of diagnosis, cases are diagnosed more frequently than heretofore and death reports are also more accurate.
3. There is a true increased incidence in certain forms of cancer such as cancer of the lung. Some have called attention to the fact that the increase in cancer of the lung parallels the increase in cigarette consumption in this country.

The term cancer does not represent a single disease entity but is an all inclusive term which takes in the various types of carcinoma, the various types of sarcoma, the different leukemias, Hodgkin's disease, and Wilms' tumor.

C. W. M. Poynter Foundation Lecture. Delivered at University of Nebraska Medical School, Omaha, Nebraska, January 12, 1948.

Multiple Primary Tumors. — In the largest number of cases the patient has one primary cancer. However, some patients present themselves with two primary cancers, differing in histological structure and taking their origin in two different organ systems. In another group, the patient is cured of one primary cancer. Many years later he returns with another primary tumor different in histological structure and origin from the first tumor. For example, the patient who is cured of cancer of bladder or penis, many years later develops a cancer of the colon. One of my patients had three primary cancers.[3]

Fields Of Activity In Cancer Research. — More knowledge has been acquired about cancer during the past fifty years than has been known since the beginning of time. Heretofore, the surgeon and the pathologist were the only ones interested in the cancer problem. The study of cancer today has broadened to include the sciences of bacteriology, biology, botany, chemistry, cytology, cytochemistry, endocrinology, enzymology, genetics, mutations, nutrition, pathology, physics, physiology and pharmacology, protozoology, tissue culture, virology, and the study of proteins, steroids, and vitamins.

The solution of the cance problem may come through the integration of facts and theories developed by the efforts of many investigators working in the various fields of cancer research.

The Role of Heredity. — The question of the part heredity plays in cancer is not only of interest to the physician, surgeon and research worker, but also to the average man or woman who is concerned with his or her individual well-being.

Attention was directed to the hereditary aspect of cancer by Maud Slye who conducted intensive experimental studies on the incidence of mouse tumors. She demonstrated that selective inbreeding of tumor-bearing animals, greatly increased the incidence of tumors. One of the conclusions she came to was the recessiveness of tumor in-

heritance and proposed a single recessive-factor interpretation. On the other hand, she also concluded that immunity to cancer is also inherited as a dominant character.

Some geneticists do not accept all of Slye's conclusions, and believe the method of inheritance does not follow a simple Mendelian procedure, but is probably understandable on a Mendelian hypothesis involving multiple factors.

In human cancer it is very difficult to get convincing proof of hereditary patterns because the human race is not composed of pure strains and the individuals will not be of uniform types similar in hereditary elements and in their tendency to form cancer of one or another variety.

For a person to take a fatalistic attitude concerning his having cancer because he comes from a so-called "cancer family" is unjustifiable because present day knowledge does not bear this out conclusively in the human, although it does in the animal. It only means that an individual, with a history of cancer in the family, should be alert and consult his physician when any symptoms or change in functions are present.

The Biologic Approach. — The biologic approach will aid the scientist in determining how growth has gone wrong and become abnormal. Research has indicated that the secret of cancer probably lies in the cell itself. More basic knowledge is needed for comparing the malignant growth with the corresponding normal. According to Reimann[4], the problems involved from the biologic point of view are: "How does the cancer cell get that way? How far can a cell normal or cancerous differentiate until it can no longer divide? What potencies remain in cells after some of their original complement has been expressed? What environmental chemical factors govern potencies and with what intracellular substances do they react to form what new substances? What are the qualitative changes when a cancer cell or cells originate? What are the enzyme patterns catalyzing these reactions both in the normal and in that cell that is cancerous: in that cell which has undergone 'somatic mutation'; in that cell which is no longer quantitatively different but qualitatively?"

The Virus Theory of Cancer. — Cancer has been produced in certain animals by a virus. Examples are the virus leucosis in chickens; the Rous sarcoma of chickens, the Shope papilloma of Western cottontail rabbits, and Lucke's work on the adenocarcinoma of the kidneys of leopard frogs.

Bittner's work on mammary cancer showed that a large percentage of normally low-cancer strain mice will develop cancer of the breast when they are foster-fed by a high-cancer strain mother. Conversely, when the offspring of a high cancer strain mother are removed by caesarian section to prevent them from suckling from her, and are foster-fed by a mother from a strain in which cancer is practically non-existent, the expected occurrence of cancer in these offspring does not take place.

It was suggested that some cancer inciter is transmitted in the milk of the mother mouse. This inciter is known as the Bittner milk influence, the Bittner milk factor, or the transmissible agent. Dr Robert G. Green stated that the Bittner transmissible agent was probably a virus.

As yet there is no conclusive evidence that human cancer is caused by a virus. It is hoped that if Green's results with cancer of the breast of the mouse can be confirmed for human cancer, that the control of human cancer will become far greater than heretofore.

Not all workers support the virus theory. They call attention to the fact that if the virus is to be considered as the cause of all cancers, some explanation must be given to those cancers produced by x-rays, carcinogenic agents, etc.

Enzymes and Cancer. — Research investigations have revealed that there are many differences and deficiences in the enzyme pattern of cancer and normal cells.

Greenstein studied a number of enzyme systems in a wide variety of tumors. In comparison with normal tissues of origin, the activity of various enzymes may decrease, increase, or show no alteration. Thus, each tumor type has its own characteristic enzymes. Whether or not in the metabolic processes of a normal cell there are enzyme changes in the metabolism of the cell which may result in changing a normal cell to a cancer cell is still unknown which offers a wide field for speculation and investigation.

Vitamins and Cancer. — Williams and his associates have made the observation that there is a specifically different chemical pattern in

cancer cells as compared to normal cells in respect to their content of certain B. vitamins.

The quantitative demonstration of differences between the chemical constituents of normal versus cancer emphasizes the necessity for further study of the physicochemical differences between cancer cells and normal cells.

Hormones and Cancer. — It is believed by some that at times there occurs a disturbance in the body's production of hormones and alters their chemical composition so as to produce cancer in the very body cells normally benefited by them. It has been found that certain sex hormones appear to be carcinogenic. For example, it is possible to introduce the female hormones from the ovary into castrated male mice and produce cancer of the breast about as frequently as it occurs in the female mouse.

The application of estrogens over long periods have produced uterine, pituitary, testicular, lymphoid and bone malignancies in mice and other animals. It has been noted that in strains with a hereditary tendency, the hormone may be a hastening influence toward malignancy development.

In certain strains of animals malignant growths of the uterine cervix were elicited in over 50 per cent of the animals that received estradiol benzoate weekly for one year or more; also prolonged treatment of male animals led to the appearance of tumors of the interstitial cells of the testis.

These studies indicate that estrogenic compounds initiate in some unknown way a number of neoplastic processes, usually of tissues that are normally under the influence of sex hormones. In view of the carcinogenic potentiality in some of these hormones, a word of caution is in order against the indiscriminate use of hormones, which will be discussed under treatment.

Carcinogenic Agents. — Physical and chemical agents may be the initiators of cancers or other growths. These agents are usually designated as carcinogenic and all carcinogenic agents do not produce the same type of tumor. They also give rise to other growths, depending on the type of cells on which they were used. There is no general chemical pattern among these carcinogens and the problem is to find a naturally occurring carcinogen.

This new chapter in experimental cancer research was opened up by two Japanese pathologists, Yamagiwa and Ichikawa when in 1918 they reported that continuous painting of rabbits' ears with tar led to the appearance of cancer. Three years ago, English workers under the leadership of Kennaway and Cook, succeeded in isolating from tar a definite organic chemical (3,4-benzypyrene) which produced cancer in mice. This led to the artificial synthesis of a wide range of organic cancer-producing compounds, the fundamental component of many of which is anthracene.

One of the most active of these carcinogenic hydrocarbons is 20-methyl-cholanthrene. This compound is closely related to, and can be produced from, cholic acid which is a normal constituent of human bile. It is also closely related chemically to the sterols, which include the male and female sex hormones. Likewise, the chemical structure of steroids and certain vitamins closely resemble certain known chemical carcinogens.

Chemical carcinogens have been used in the production of experimental cancers in animals and so far not much light has been thrown on the causation of human cancer. Since methylcholanthrene is a close chemical relative of cholic acid, the question arises whether or not a slight shift in the chemical structure of naturally occurring cholic acid, might give rise to a carcinogen similar to methylcholanthrene being responsible for the causation of human cancer. Similarly other chemical carcinogens produced in the test tube have a striking intimate relationship to other substances which occur naturally in the human body. Shabad elicited some sarcomas and an increase in the number of other tumors in mice injected with extracts of liver from patients with cancer.

Not only carcinogenic hydrocarbons and sterols have produced cancer in experimental animals, but a large variety of chemical compounds of entirely different composition have caused cancer. The fact that such a variety of entirely unrelated chemical compounds have produced cancer leads to the belief that none of them is to be considered as the over-all primary cause of the cancer process. Some other factor or factors must also operate. Identification of the active chemicals has not yet been achieved.

Embryonic Theory of Cancer. — The modern embryonal theory was placed on a comprehensive basis by Cohnheim who postulated that neoplasms

arise from simple or complex tissue misplaced during embryonal development, and which retain a special proliferative potency.

Cohnheim's theory explains the structure and occurrence of many tumors, but it fails to explain why the embryonal cells begin to grow and when they do grow why malignant tumors result instead of normal structures.

Trauma and Cancer. — The role that trauma plays in the development of cancer or sarcoma is of great medicolegal importance. By trauma, we mean a single mechanical blow or injury. If a persons sustains a blow and one month later develops a growth at the site of injury, we know that the tumor antedated the injury or accident, because we also know that the tumor could never grow that rapidly.

Because of the medico-legal implications, it is imperative that the physician obtain an accurate history in which is detailed minutely the sequence of events. Ewing[5] has made the following statement: "It becomes necessary to determine in each instance just how far the trauma acted and how it acted, and if it were really important, and on this account in all properly conducted medico-legal inquiries we establish certain criteria which must be met before one can assume that a trauma is related to a tumor."

Chronic Irritation and Cancer; Occupational Cancer. — Chronic irritation can produce cancer. Early workers with roentgen rays were unfamiliar with the fact that repeated exposures to the roengen rays would result in cancer. Today, ample precautions are taken against this possibility.

A word of caution at this time is in order. The use of the x-ray as an agent for removing superfluous hair by beauticians and technicians has resulted in keratoses, disfigurement and ulceration that were suspicious for cancer, not necessarily immediately after the treatment but many years later. The public should be informed of the danger of these new contrivances that are advertised as free from danger.

Overexposure to the sun, wind and weather is sailors are apt to develop an increased proportion of skin cancer.

As further evidence of the role of irritation in the production of cancer may be mentioned the presence of rough, jagged teeth; holding a plug of tobacco habitually in the same side of the mouth, the smoking of pipes and strong cigars, and the chewing of betel nut.

That the lung is not immune to the effects of chronic irritation is seen by the increased incidence of lung cancer. Although the evidence is not conclusive, concerning the relation between the use of tobacco and the incidence of lung cancer, it does not seem unlikely that repeated filling of the lungs with a suspension of fine particles of tobacco does cause a certain amount of irritation.

Other examples of chronic irritation or exposure to certain chemicals are those encountered in various occupations. For example, the chimney sweep's cancer of skin from soot; skin cancer in cotton spinners due to mineral oil; cancer of lip in fishermen repairing tarred nets; cancer of bones in workers with luminous paints; cancer of bladder in workers with anilin dyes; cancer of lungs in some miners.

Diet and Cancer. — There has been much talk about diet and cancer. Almost every type of food has been blamed by the public for the origin of cancer. So far as is now known, diet has no effect on the incidence of human cancer.

Infectiousness of Cancer. — There is no evidence that cancer is a germ disease, such as pneumonia or tuberculosis. Cancer is not contagious. Of the recorded cases, we do not find a report of a person, who has been in close contact with a cancer patient, of ever having acquired cancer from that cancer patient. Physicians have even carried out experiments by inoculating themselves with cancer, but no cancer resulted.

Animal Experimentation. — The study of cancer cannot be carried out without the use of experimental animals. Without the use of animals much of our present day knowledge concerning cancer could not have been obtained. In order to continue our cancer research on a large scale, not only the medical profession, but the laity itself, who benefits most from this knowledge, must see to it that fanatics do not hinder the continuation of research. Our duty as physicians is to educate these fanatics, appraising them of the advantages that accrue to the animal, as well as to man.

Cancer Prevention. — Certain types of cancer are preventable. Jagged teeth should be removed to avoid irritation. The cessation of

smoking by a man who has an irritation and leukoplakia in his mouth will avoid further irritation. Industry has instituted hygienic measures and precautions to be observed so that the cancer incidence is not as great where workers are exposed to irritating fumes and substances, e.g., the aniline dye workers who are apt to get cancer of the bladder.

Papillomas of the bladder can be cured by fulguration, before they enter into the cancerous stage. It is a well known fact that the Mohammedans and Jews, who practice ritual circumcision, have practically no cancer of the glans penis. Early circumcision is recommended.

Cancer Control. — Cancer in its early stages is curable. The most effective measure is the periodic examination of men and women and children in the susceptible ages. Cancer can be controlled to a great extent by:

(1) The education of the public;
(2) The alertness of the physician to the problem.

The American Medical Association, the American College of Surgeons, the American Society for the Control of Cancer, the various State medical societies have all been launching educational programs to enlighten the public. These campaigns are concerned with acquainting the public with the facts of cancer and educating them to come early to the physician when any untoward signs or symptoms appear.

The educational program has stressed certain danger signals which point to the possibility of cancer and which should make the person see his physician at once. These symptoms are:

(1) Any persistent lump, particularly in the breast.
(2) Any irregular bleeding or discharge from any part of the body.
(3) Any sore that does not heal, particularly about tongue, mouth or lips.
(4) Persistent indigestion or change in bowel habits.
(5) Persistent hoarseness or cough, difficulty in swallowing.
(6) Sudden changes in the form or rate of growth of a mole or wart.
(7) Pain. This is usually a late symptom and one should not wait for it to appear, especially when pain is present along with any of the above symptoms.

The medical profession has assumed the responsibility for the program of education and cancer control. One of the developments has been the establishment of cancer detection clinics. The function these cancer detection clinics is the examination of apparently healthy individuals for the discovery of cancer in its early stages. In a period of 9 months, 1,709 persons were examined in detection centers in the state of Maryland. In this group, 17 carcinomas were found, a rate of 1%. Statistics published to date from detection centers in other states revealed cancer in as high as 7.6% of persons examined.

The role of the physician in cancer control is a most important one. Every practitioner of medicine will at some time have to deal with cancer patients. He should not be slip-shod in his examination. A thorough history should be taken particularly in patients over 40 years of age. The complete physical examination, including laboratory tests, and x-rays, must be carried out when there is the least suspicion that the patient may have cancer. Many a harmless-appearing lump on the skin turns out to be a cancer and the physician should scrutinize all nodules, moles and unhealed scars on the skin. Bleeding from the urinary tract, the vagina, bladder, or rectum, or nipple are danger signals and must receive due consideration.

Every woman's breast should be examined for lumps. The uterus should be examined for enlargement, lacerations, bleeding or new growths; the condition of the ovaries should be determined.

Indigestion, loss of appetite and loss of weight might mean a lesion of the gastro-intestinal tract. Any change in bowel habits should call for study.

The lymphatic system should be examined for enlargement of the nodes of neck, armpit or groin.

Difficulty in swallowing, chronic hoarseness or chronic dry cough are not always due to smoking.

Treatment. — The best form of treatment in any organ is early diagnosis and early treatment. Surgery is still the treatment of choice, either alone or combined with radium or x-rays. Some tumors of the urinary bladder, such as papillomata are cured by the use of the high frequency current.

The splendid results obtained today are due to early diagnosis and radical surgical removal

of the cancer. Radical operations are possible today due to improvements in surgical technique, blood transfusions, the use of antibiotics and new types of anesthesia.

It is much too early to place any evaluation on the use of atomic energy in the treatment of cancer.

The use of tracer substances in the diagnosis and treatment of cancer has opened up a new avenue to the approach of the cancer problem.

The use of urethane and nitrogen mustard are without any curative value.

Estrogenic materials have been used in the treatment of cancer of the prostate. The action is not curative, although it relieves the victim of some of the discomforts arising from this disease. Recently, interest has been aroused in the use of testosterone in mammary cancer. In some cases it seems to have a palliative effect. Other cases may be made immeasurably worse. At times the cancer can be caused to progress rapidly. The indiscriminate use of hormones in cancer is associated with dangers to such patients. This form of treatment is still in the experimental stage.

Recently in a report from the Therapeutic Trials Committee of the Council on Pharmacy and Chemistry of the American Medical Association, the following was emphasized:

"Because of the inherent dangers of indiscriminate steroid therapy of mammary cancer, the experimental nature of this therapy must be emphasized. The Subcommittee believes it imperative to reemphasize the known dangers and to point out that others may be discovered in the investigations now contemplated."

Cholesterol-Basal Metabolism Determinations

Clinical Observations in 830 Cases

James H. Hutton, M.D. and Stanley Fahlstrom, M.D.
Chicago

Introduction. There is common belief that hypercholesteremia and low basal metabolism are reciprocal findings in thyroid deficiency; that hypercholesteremia, in the absence of other causes, points more to thyroid deficiency than does a low basal metabolism; that the blood cholesterol estimation may provide a guide in the treatment of thyroid disease; and that true thyroid deficiency is always accompanied by hypercholesteremia[1,2].

Hypercholesteremia is said, also, to occur in diabetes mellitus (acidotic stage), nephrosis, chronic nephritis (nephrotic stage), pregnancy, obstructive jaundice (cholesterol ester determination is apparently of greater importance in liver infection and parenchymatous liver disease), malignancy, coeliac disease and in hemorrhagic and aplastic anemias.[3,4]

Cholesterol is a simple, monatomic, unsaturated, secondary alcohol widely distributed in the body, structurally related to vitamin D, and occurs free and combined in the blood with similar concentrations in plasma and whole blood. Diet and fasting apparently do not influence the level. A gradual and slight increase with age is noted throughout childhood. Variations from normal cholesterol values are said to be large in hypothyroidism and that small changes in the metabolic rate effect relatively large changes in the level, according to Weinhouse.[5]

In the belief that hypercholesteremia occured too infrequently to be of real significance in the diagnosis or evaluation of hypothyroidism, the authors surveyed a fairly large number of consecutive cases seen for the first time.

Plan of Study. A total of 830 patients was studied. A great many of these were endocrine problems but, with a multiplicity of allied conditions, they represented a wide cross-section of clinical diagnoses. Using modern and standard

TABLE 1

Total Number of Cases in Series				830
Males	257 or 31%			
Females	573 or 69%			
Underweight				
Male	43)			
	)			
Female	76)	or 14.4%		119
Normal (Weight)				
Male	94)			
	)			
Female	194)	or 34.7%		288
Overweight				
Male	120)			
	)			
Female	303)	or 50.9%		423
				830

Averages

	Age	Weight
Underweight	29 years	118 pounds
Normal	36 years	135 pounds
Overweight	26 years	185 pounds
Ages 9 to 72 years	Weights 48 to 390 pounds	

height-age-weight tables and permitting up to 10% plus or minus values, these cases were then divided into three groups—underweight, normal weight and overweight — disregarding clinical diagnoses.

Cholesterol and basal metabolism tests were performed on all patients. Laboratory values were then determined and rated as low, normal or high. These results were then plotted for analysis.

Laboratory methods used. The cholesterol test used was the modified Bloor (6) with normal values from 150 to 230 mg. per 100 c.c. of blood. Basal metabolism tests were made with a Sanborn apparatus. Plus 10% to minus 10% was considered normal.

Results. (Table 1) There were 257 males (31%) and 573 females (69%) studied. Of these 119 were underweight (14.4%), 288 were of normal weight (34.7%) and 423 were overweight (50.9%). Ages averaged 29, 36 and 26 years; weights 118, 135 and 185 pounds respectively. Ages varied from 9 to 72 years; weights from 48 to 390 pounds. A division of ages by decades (Table 2) disclosed the largest group from 11 to 20 years (26.1%). Other values were 21.3% from 31 to 40, 18.9% from 41 to 50, 16.5% from 21 to 30, 12.2% from 51 to 60, 3% from 61 to 70 and 0.1% above 71 years of age.

TABLE 2

Decade	Under-weight	Normal	Over-weight	Totals
1 - 10	1	12	2	15 or 1.9%
11 - 20	16	151	50	217 or 26.1%
21 - 30	23	71	43	137 or 16.5%
31 - 40	48	70	59	177 or 21.3%
41 - 50	16	69	72	157 or 18.9%
51 - 60	9	41	51	101 or 12.2%
61 - 70	5	9	11	25 or 3.0%
71 - 80	1	—	—	1 or 0.1%
	119	423	288	830 or 100 %

Basal metabolic rates (Table 3) were low in 334 or 40% of the total cases. Of these 42 were underweight, 121 were normal and 171 were overweight. Three hundred and eighty-one (46%) revealed normal and 115 (14%) high basal metabolic rates.

Hypercholesteremia occurred in only 7 cases (0.84%), which contrasted very sharply with 334 (40%) with low basal metabolism. Two hundred and seven cases (25%) and 616 cases (74%) showed low and normal cholesterol values respectively.

Cholesterol determinations in the 334 cases with low metabolism (Table 4) revealed 61 (18.3%) low, 269 (80.5%) normal and only 4 (1.2%) with hypercholesteremia.

Clinical Data. (Table 5) Of the 7 patients with hypercholesteremia 6 were overweight and 1 of normal weight. Six were over 45 years of age, one was 23. Average age was 49 years. Almost all showed evidence of thyroid and pituitary deficiency with hypertension in 3. Weight averaged 194 pounds. There were 6 females and 1 male. Cholesterol determinations varied from 231 to 250 mgm. There were two normal and one high basal metabolic readings. None of the 4 cases with hypercholesteremia and low basal metabolism showed any cinical sign of myxedema. None of the 7 patients showed any clinical resemblance to any of the conditions previously stated to be associated with hypercholesteremia.

Conclusions. When 830 cases were studied with both basal metabolism and blood cholesterol determinations, a fair percentage—40% or 334 cases—showed low metabolism and an insignificant percentage—0.84% or 7 cases—a hypercholesteremia. Such a marked disproportion throws serious doubt on the value of cholesterol

TABLE 3

830 BMR and Cholesterol Test Results

		Low	Normal	High	Total Cases
Underweight	119 cases				
BMR					
	Male	21	13	9	43
	Female	21	39	16	76
		42 or 5.0%	52 or 6.3%	25 or 3.0%	119
Cholesterol					
	Male	12	25	—	37
	Female	22	60	—	82
		34 or 4.1%	85 or 10.3%	0 or 0.0%	119
Normal	288 cases				
BMR					
	Male	40	46	8	94
	Female	81	87	26	194
		121 or 14.6%	133 or 16.0%	34 or 4.1%	288
Cholesterol					
	Male	35	59	—	94
	Female	54	139	1	194
		89 or 10.7%	198 or 23.9%	1 or 0.1%	288
Overweight	423 cases				
BMR					
	Male	63	43	14	120
	Female	108	153	42	303
		171 or 20.6%	196 or 23.6%	56 or 6.8%	423
Cholesterol					
	Male	25	94	1	120
	Female	59	239	5	303
		84 or 10.1%	333 or 40.1%	6 or 0.7%	423
Grand Totals (Approximate)					
	BMR	334 or 40.0%	381 or 46.0%	115 or 14.0%	830
	Cholesterol	207 or 25.0%	616 or 74.0%	7 or 1.0% (0.84%)	830

TABLE 4

Cholesterol Values in 334 Cases Who Showed Low BMR's

	Total Cases	Low	Normal	High
Underweight				
Male	19	2	17	—
Female	24	3	21	—
	43	5 or 1.5%	38 or 11.4%	0 or 0.0%
Normal				
Male	43	11	32	—
Female	67	14	52	1
	110	25 or 7.5%	84 or 25.1%	1 or 0.3%
Overweight				
Male	66	15	50	1
Female	115	16	97	2
	181	31 or 9.3%	147 or 44.0%	3 or 0.9%
Grand Totals	334	61 or 18.3%	269 or 80.5%	4 or 1.2%

TABLE 5

Clinical Data on 7 Cases with High Cholesterol

1 — M.M. Female, obese, age 58 years, height 70 inches, weight 205 pounds, BMR + 23%, cholesterol 240 mg. Hypertension, atherosclerosis. Tolerates 8 gr. thyroid daily.

2 — S.M.E. Female, obese, age 23 years, height 60 inches, weight 222 pounds, BMR — 12%, cholesterol 245 mg. Pituitary-thyroid deficiency.

3 — K.P. Male, obese, aged 45 years, height 66-3/4 inches, weight 212 pounds, BMR — 29%, cholesterol 250 mg. Pituitary-thyroid deficiency.

4 — M.M. Female, obese, age 65 years, height 62 inches, weight 213 pounds, BMR — 10%, cholesterol 250 mg. Hypertension, pituitary-thyroid deficiency.

5 — E.N. Female, obese, age 63 years, height 62 inches, weight 194 pounds, BMR — 2%, cholesterol 231 mg. Hypertension, pituitary-thyroid deficiency.

6 — M.L. Female, obese, aged 38 years, height 62-1/2 inches, weight 189 pounds, BMR — 14%, cholesterol 237.1 mg. Psychoneurosis, pituitary-thyroid deficiency.

7 — C.H. Female, normal weight, aged 51 years, height 60-1/2 inches, weight 139 pounds, BMR — 19%, cholesterol 250 mg. Menopause.

determinations as a guide in hypothyroidism. It may be said that other factors besides the thyroid can be responsible for low basal metabolism. However, the size of this series studied—the majority of whom had some endocrinopathy—makes it very unlikely that the cholesterol test per se has any but academic value as a routine test in problems of internal medicine. Incidentally the series studied contained 15 diabetics. None showed hypercholesteremia; 13 had normal and 2 had low values. A consecutive survey of 50 cases with low basal metabolism of minus 20% or lower (-20 to -37%) showed 48 with normal cholesterol, 1 low and 1 with hypercholesteremia. This latter case was the only one of 7 with hypercholesteremia with a basal metabolism of over minus 20%, i.e. minus 29%.

SUMMARY

1. Conditions which are said to be associated with hypercholesteremia are given.

2. Characteristics of cholesterol are briefly discussed.

3. A plan for cholesterol—basal metabolism study is given.

4. The laboratory methods used are noted.

5. Data in 830 consecutive patients—largely subjects with some endocrinopathy—are shown as to age, weight, sex, weight-grouping and results obtained from standard cholesterol and basal metabolism determinations.

6. Clinical data are given for the small percentage of patients—0.84% or 7 cases—who revealed hypercholesteremia.

7. It is the author's conclusion that the blood cholesterol test per se is of little or doubtful value as a routine laboratory procedure in medical practice. It is probably of value in true myxedema or as a special study in certain specific indications.

30 North Michigan Avenue

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SALICYLATES IN RHEUMATIC FEVER

The opinion is now quite general that while there are remedies better than the salicylates to alleviate the joint pains and control the fever of the acute rheumatic state, they do not have any effect on the disease or influence the development of the cardiac complication. Consequently, while salicylates are still used to relieve pain and temperature, they are usually discontinued as soon as the patient complains of aural signs of intolerance or if vomiting indicates the beginning of the gastric irritation.—*International Medical Digest.*

Thrombophlebitis and Phlebothrombosis

Garland O. Welland, M.D.
Rockford

The problem of venous thrombosis and its most serious complication, pulmonary embolism, rightly commands the continued interest of all physicians. Because of this, I wish to take this opportunity to discuss with you and review some of the more recent advancements concerning thrombophlebitis and phlebothrombosis.

Phlebothrombosis is defined as a venous occlusion unassociated with inflammation, the clot being loosely attached to the vein wall. It has a tendency to propagate rapidly and easily become dislodged to produce an embolus. Thrombophlebitis is considered as clotting associated with and dependent upon inflammation of the vein wall, with the result that such clots are usually firmly attached. This is purely a basic and fundamental distinction.

The exact causes of intravascular clotting are still a mystery, however we are aware of many predisposing conditions. Briefly, these may be enumerated as sex, age, predisposing diseases or conditions such as pregnancy, abdominal operations, malignancies, sickle-cell anemia, cardiac decompensation, as well as injuries, obesity, infection, burns and many others.

It has been customary since the teachings of early pathologists to regard slowing of the circulation, changes in the vessel wall, and increased coagulability of the blood as the three factors responsible for thrombosis. These are frequently found existing together rather than as separate factors. The first two of these factors need no futher discussion. Increased coagulability of the blood is brought about by many states. Any trauma which liberates thrombokinase from the tissues will do so; this occurs after massive injuries to muscle — after any major operation. Loss of plasma in burns and shock, dehydration due to vomiting or rapid diuresis after mercurials produces hemoconcentration and increased viscosity. Patients with polycythemia or those suffering from carcinoma also come under this group.

Any person of a group of patients presenting the problem of peripheral vascular diseases with venous thrombosis may be classified as having either one or a combination of several of the following syndromes:

1. Superficial phlebitis of pre-existing varicosities, ascending toward the groin. No, or very little, edema exists. No spasm in calf muscle is present. Large, red, painful thrombi are visible and palpable.

2. Ascending plantar vein thrombosis syndrome in which there is pressure pain over the lateral aspect of the foot, later over the inner malleolus, then over the posterior tibial vein. Pain is present with dorsiflexion of the foot. The clot seems to ascend from day to day. The thigh becomes tender and swollen. The femoral artery pulsates more feebly and the oscillations are increased on the affected side. Embolism is frequent.

3. Calf muscle thrombosis syndrome. No plantar vein involvement is present but there are aches, cramps and tightness of the calf. There is spasm on dorsiflexion and increased temperature over the affected calf, with increased oscillations. The femoral vein is not tender. Temperature and white blood cell counts are normal. Emboli are frequently latent and unrecognized until embolism, and

4. Pelvic vein thrombosis syndrome. Pain and swelling in the buttocks or the adductor muscles close to the inguinal fold occurs, as does sciatic neuritis, urinary frequency, mucous diarrhea, or slight suprapubic edema. Palpable cords lateral to the prostate or uterus may confirm the diagnosis. Embolism is not frequent as long as the thrombosis is intrapelvic.

With the exception of a few entities all cases of peripheral vascular venous thrombosis can be classified under these syndromes. Therefore we

Read before AFPAC Medical Convention, Tokyo, Japan, October, 1946.

note the very high incidence of involvement of the veins of the legs and feet as the sources of thrombotic emboli — a vital feature of the problem from the point of view of prevention and treatment.

Lack of recognition that the deep veins of the leg are the most frequent site of thrombosis and the most prolific sources of both fatal and nonfatal pulmonary embolism long remained unknown for two reasons: (1) Symptoms referable to such thrombosis are likely to be absent or are so slight that they are overlooked clinically and (2) restrictions upon necropsy dissection of the extremities. Such men as de Takats of Chicago, Ochsner of New Orleans, Homans, Fine and Starr of Boston, as well as others have contributed greatly to the clarification of this problem. As early as 1934, Homas[1], supported by clinical and pathological-anatomic observations, emphasized the great importance of the veins of the calf as areas of orgin of ascending thrombi. In 1937, Rossle[2] of Germany, in a report of 324 post mortem examinations in persons over 20 years of age, found 27.1% incidence of thrombi in the veins of the calf. In only seven instances did he find thrombosis of the femoral or hypogastric veins in the absence of thrombosed leg veins. Recently, Hunter, Sneeden and Robertson and Snyder[3], in a report of 351 autopsies reached the following conclusions:

1. 52.7% incidence of thrombosis of the deep leg veins among middle-aged and older persons forced to bed for varying periods of time. This was thought to be the greatest single factor favoring thrombus formation.

2. Bilateral involvement was found 110 times and unilateral, 75 times.

3. Fatal pulmonary embolism was responsible for 3.13% of all deaths; in 45.4% of the cases of death from such embolism the most probable source was thrombosed leg veins.

4. Phlebitis, either as a cause or as a complication of thrombosis has a minor role (8.1%), and

5. Planned and supervised voluntary movement and the elimination of too much comfort for the legs should do much to reduce the incidence of thrombosis and its all to frequent sequel, pulmonary embolism. In comparison with a control group, the incidence of phlebothrombosis was 35.1% less among those who were exercised.

The clinical evidence of a deep, quiet venous thrombosis in the calf is quite different in ambulatory persons and in those already confined to bed. No age beyond infancy is free from the accident of thrombosis, though it is most common in the 6th decade and beyond. When attacked in an active life, the individual may notice some degree of lameness of the calf in walking, some little edema of the ankle; occasionally only such vague symptoms as hardly to trouble a busy person. There may have been a minor accident or unaccustomed strain. Any lameness and swelling which are present will be relieved by a few days' rest in bed, but will recur on renewed use of the limb.

When thrombosis occurs during posttraumatic, postoperative or postpartum life in bed, or in the course of any serious illness, there may be even less to call attention to the local disease. It is under these circumstances that embolism is so apt to come out of a clear sky. However there is often pain in the calf, ranging from mere soreness to a real ache. There may or may not be some swelling of the ankle and lower leg. There may be tenderness of some toes, of the foot or of the calf. More especially, there may be some signs of irritability of the great posterior calf muscles. This can be brought out by strong dorsiflexion of the foot — Homan's sign. The muscle may merely resist passive dorsiflexion, which will be less complete upon the opposite side, or there may be discomfort, referred to the back of the calf or the popliteal space. The muscles, to the grasp of the fingers will often feel full and a little tense. Finally if the individual can sit or stand up, the foot of the dependent leg will perhaps appear faintly cyanotic, again as compared with the opposite side.

It may be necessary to leave the legs dependent for several minutes to bring out this sign.

In September, 1943, Dr. Jerome Mark[4] of Detroit, Michigan, and in June, 1944, Lesser and Danelius[5] at McCaw General Hospital, Walla Walla, Washington, reported the use of venography in the differential diagnosis of the peripheral venous circulation. There were no re-

ports of reactions or thrombosis following the injections of the diadrast solution they used.

By the use of venography one is able to determine with considerable accuracy the major features of the superficial, deep communicating veins and tributaries. Venography may then, become a valuable means of demonstrating deep venous thrombosis early in the disease where otherwise it might be allowed to proceed to thrombus formation and a fatal termination by pulmonary embolus. The importance of early recognization of deep vein thrombosis is generally recognized. A mortality rate of 8-10% has been reported by many clinics due to pulmonary infarction resulting from deep phlebothrombosis.

Venographic pictures of deep vein thrombosis are of two distinct types, depending upon whether venography is performed during the immediate acute episode or at a later date, when organization and recanalization have occurred. One is unable however, to differentiate by this means, whether the obstruction of the deep veins is due to thrombophlebitis or phlebothrombosis. The acute, immediate deep vein thromboses are characterized by the presence of many fine "hair-pin-like" venous markings in the leg and lower thigh. These were thought to be a group of previously unused small venous collaterals. The major deep veins frequently showed sudden blunting obstructions and sharp segmental defects in the lumen.

On the other hand, the venographic picture in the case of chronic or old deep vein thrombosis is characterized by a partial or total abscence of visualization of the femoral vein, the popliteal vein or the communicating veins of the leg. Marked irregular narrowing defects giving a patchy appearance of the vein may be noted. The superficial venous return is usually quite prominent and frequently tortuous.

Many clinicians, however, do not agree entirely with Mark, Lesser and Danelius and others about the use of venography. de Takats and Fowler[6] do not believe it should be used routinely. Fine, Frank and Starr[7] of Boston state that, "venography is an indispensable technique for the correct management of all types of thrombophlebitis of the lower extremities." Personally, I believe venography is a "tool" in the hands of the clinicians which, if used more routinely and correctly, will aid materially in arriving at an earlier and correct diagnosis of peripheral venous thromboses, and in turn help to prevent many pulmonary accidents resulting from embolism.

As for the treatment of these conditions, one may conveniently discuss those under two chief headings — conservative and radical.

In regards to the conservative methods, for centuries the swollen milk-leg was immobilized and elevated, the patient being kept in bed for an arbitrary four to six weeks, after which the patient must wear an elastic stocking from the toes to the groin for 6-12 months. Many patients have done well under this regime, but the chief fault is that the residual edema and possibility of embolism are entirely left to chance.

Paravertebral sympathetic blocks are frequently used. Some of the symptoms following venous thrombosis are due to a spasm in the peripheral vascular tree. This is especially evident when the illiofemoral segment is suddenly occluded and is surrounded by a periphlebitic exudate. A paravertebral block of the lumbar sympathetics will relieve the pain, and much of the edema and restore the arterial pulsations, which are frequently diminished. This method if used alone will not protect the patient from an embolus however.

Since about 1933 Roentgen-ray therapy has been used to hasten the absorption of the thrombophlebitic edema. Only a few very small doses (100-125 r. units) are given as indicated and the effect on the periphlebitic exudate and on the concomitant lymphangitis and lymphadenitis is sometimes remarkable.

Also under the conservative type of treatment the anticoagulant therapy must be included. This has its greatest use to prevent the propagation of the existing clot. de Takats and Fowler[8] of Chicago present their method of treatment as follows: Heparin is given at four-hour intervals in 50 mgms doses undiluted, intravenously. It is agreed that this will not maintain a steadily elevated coagulated time, but it is simpler for the patient and its protective value is equally efficient. Simultaneously, oral administration of dicoumarol is started, 300 mgms the first, and 200 mgms the second day. Prothrombin levels must be determined daily. The level must be kept between 60 and 30% of the normal prothrombin time and the dosage

of dicoumarol must be adapted to the daily determinations. May I add a note here in regards to the use of dicoumarol and Heparin. It is imperative that you be absolutely certain of the capabilities of your laboratory technicians in arriving at correct results in determining the prothrombin levels. Unless you can be sure of this, it is advisable to discontinue the use of the anticoagulants. Heparin is discontinued usually after two days, when the action of dicoumarol has become manifest. Dicoumarol is used until the patient becomes ambulatory, which is usually 8-10 days. It may be given over periods of several months without any deleterious effects. However, after discontinuation of the dicoumarol the patient has no further protection against thrombus formation. With adequate dosage and slow tapering off with discontinuation of the drug, no such phenomena are likely to be observed.

The treatment of phlebothrombosis is always radical. As mentioned previously, this type of intravenous clotting is accompanied with few or no manifestations. These patients do not appear ill, but they represent potential fatalities, because the clot not being attached to the vein wall, is likely to become detached and result in a fatal pulmonary embolism. Unless measures are taken to prevent the clot from getting into the systemic circulation after it becomes detached, a tragedy will result.

In suspected cases of phlebothrombosis and also in those cases in which a pulmonary infarct has occurred, ligation of the involved vein above the thrombus is imperative. Because in many instances thrombosis is bilateral, it is desirable to do a bilateral femoral ligation. There is no doubt that this is being accepted and performed more often in clinics today. Allen and his co-workers reported in 1943 an increasing incidence of femoral vein ligation at Massachusetts General Hospital from the year 1937 when only one ligation was done to the year 1942, when 211 were performed. 61% of the operations were unilateral and 37% were bilateral. Some surgeons advocate doing a thrombectomy in phlebothrombosis and repair of the vein.

The selection of the level of ligation is made on the basis of the evidence of the extent of involvement: (a) the common femoral vein is ligated when the disease is limited to the veins below the knee, or when pulmonary embolism has occurred in the absence of all signs of involvement: (b) the common iliac is ligated when the disease involves the common femoral, external, or common iliac veins: (c) the vena cava is ligated when the indications are that both common iliacs require ligation.

Like any operative procedure, some complications are being reported from the femoral vein ligation. The chief one of these is that instances of interference with the circulation of the extremity occur following the operation. Allen and his co-workers reported that in a series of 464 vein interruptions done at the Massachusetts General Hospital, not a single case suffered from serious circulatory embarrassment. The purpose of the operation is to interrupt the long column of blood in the femoral and popliteal veins, so that if the clot forms in them it cannot be swept upwards to lodge in the pulmonary artery. Interruption of the superficial femoral vein just distal to its junction with the deep femoral may be carried out without danger to the circulation of the extremity. It is the safest level for the average surgeon to interrupt this large venous system, since the vessel at this point is free of any tributaries. At the same time, the long venous channel of the leg is interrupted at a sufficiently high level to prevent fatal embolism. The vein may be tied in continuity but division of it and ligation of each end with a primary ligature and a secondary stitch ligature distal to it in each stump is considered the best procedure. The ligatures should be of the nonabsorbable type, either silk or cotton. The safest method of anesthesia in the postoperative or very ill patient is local infiltration of 1% procaine.

The interruption of the common femoral vein proximal to the profunda branch is generally reserved for those patients in whom a thrombus is found in the common femoral vein. This surgical interruption of the common femoral vein, if it contains a thrombus, will not endanger the circulation of the extremity, since it has already been occluded. The common femoral vein is relatively short and several small tributaries drain into it, so that it is a more difficult procedure to interrupt it than the superficial femoral vein. One or two of these branches usually

must be ligated and divided separately to give sufficient length of the vein to permit its safe division and ligation. Under no circumstances should the common femoral and the saphenous vein both be interrupted, unless it is found that they are already occluded by thrombi.

In summary, we may say that the incidence of venous thrombosis in peripheral veins is much higher than ordinarily suspected. Four groups of venous thrombosis, namely, the superficial venous thrombosis, the ascending plantar vein thrombosis, the calf muscle thrombosis and the pelvic vein thrombosis, can be recognized as being the primary sources of clotting. Any one of these may produce by propagation, an iliofemoral thrombosis, the classic milk leg. The treatment of such thromboses should vary according to the primary site, the extent and age of the thrombosis. Anticoagulant therapy, paravertebral sympathetic block, proximal vein ligation, and roentgen-ray therapy all have their indications but should be used selectively. Visualization of the venous system by opaque substances is a valuable "tool" in the diagnosis of thrombosis. Pulmonary embolism is still often the earliest manifestation of an unrecognized thrombus in the periphery; its appearance calls for emergency measures, and, following recovery of the patient, for a thorough investigation of the source of the embolus, since recurrent emboli are increasingly dangerous.

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Ovarian Thecoma

Case Reports With Contrasting Symptomatology

Charles L. Patton, M.D., F.A.C.S., and
Robert J. Patton, M.D., M.S., F.A.C.S.
Springfield

The functioning ovarian neoplasms are those which produce symptoms by reason of the production of a hormone of abnormal quality or quantity. Best known are the granulosa cell tumor and the arrhenoblastoma which produce converse symptoms, the former ordinarily accentuating feminism and the latter producing masculinizing effects. Less well known are several functioning tumors such as thecoma, masculinovoblastoma and gynandroblastoma which appear to bear some genetic relationship to granulosa cell tumor or arrhenoblastoma[11] but with a varying gradation of effects on the host. With the pooling of increasing numbers of case reports and collected series, and with improved biologic and histologic methods of study, it appears that a kinship between these bizarre neoplasms may be established.

Presented before the Section on Obstetrics and Gynecology, 107th Annual Meeting of Illinois State Medicol Society.

Most logical of the proposed theories of histogenesis is that of Novak[15] who concludes that the pluripotential primitive mesenchyme may be the progenitor of theca and granulosa cell tumors. Luteinization of ovarian stromal cells appears to account for the so-called "lipoid cell" tumors in this group. That, however, each of these tumors is always a distinct and separate entity in an orderly classification does not seem likely, and admixtures of types appear to be common.

A case in point is the thecoma, or theca cell tumor, originally described as "fibroma thecacellulare xanthomatodes ovarii" by Loeffler and Priesel in 1932[13]. The usual gross features of a thecoma are those of a smooth or lobulated, firm or rubbery tumor of one ovary varying in size from that of a normal ovary to that of a large melon. Characteristic is its yellowish pink appearance through a milky or brownish capsule. It is of a fibroid nature, and the cut surface presents streaks or islands of prominent yellowish to ochre tissue often separated into lobules by septa of greyish fibrous tissue which may constitute most of the specimen. The occasional presence of cysts is attributed to degenerative necrosis.

Miscroscopically are noted interlacing bundles of connective tissue cells with rather broad spindle-shaped nuclei. Scattered throughout are islands or nests of epithelioid cells with either vacuolated or acidophilic cytoplasm and with clearly defined polyhedral cell boundaries giving the cells the appearance of luteinization. Lipoid may usually be demonstrated within the characteristic cells and occasionally extracellularly. The presence of a high phospholipid determination serves to differentiate thecoma from ovarian fibroma with fatty degeneration[9, 23]. There is an intimate relation between these cells and a surrounding reticulum as can be demonstrated by special stains. The resemblance of these cells to those of the theca layer about the normal graafian follicle gives the tumor its name. Gardner[6] considers the theca cell to be a phase of the normal stroma cell which, under the influence of the developing follicle, changes its morphology to permit rupture of the follicle. These cells may occasionally be differentiated from granulosa cells only with difficulty. Traut and Marchetti[21] feel that special silver stains demonstrate argentaffine granules in the cytoplasm of granulosa cells but not in theca cells.

With wider knowledge of these tumors and by re-examination of old specimens previously diagnosed as fibroma of the ovary, it has been shown that many of these so-called fibromas were, in fact, thecomas [7, 1]. Meig's syndrome of ascites and hydrothorax, so commonly associated with fibroma, has been reported with thecoma [2, 14, 16, 18]. Hyalinization of large areas of a thecoma is frequent.

The classical symptoms of thecoma are similar to those of granulosa cell tumor, namely those attributed to an increase in estrogenic substance. Although estrogenic substance has been demonstrated in thecomas [22], it is believed by some [21] that it cannot be found in the pure type of thecoma, and, when demonstrated, is due to the presence of granulosa cells. Whereas granulosa cell tumor is more common in young women, thecoma usually occurs in the older age group and commonly affects an individual after the menopause causing a resumption of menses, rejuvenation of libido and turgescence of the breasts. The uterus is often enlarged and the endometrium usually hyperplastic. Several observers [10, 12, 17, 23] have noted a high incidence of fibromyoma, adenomyoma and of uterine carcinoma. Pregnancy can occur in the presence of thecoma. Occasionally the only symptoms are those due to the presence of a pelvic tumor by virture of size, weight, pressure, or twisted pedicle. Rupture of a cystic thecoma has been reported[4].

Less common signs and symptoms associated with thecoma are amenorrhea, changes toward the masculine habitus, deepening of the voice, hirsutism and enlargement of the clitoris, all of which are, also, characteristic of arrhenoblastoma or masculinovoblastoma. Stout[20] has recently reported the appearance of virilism during pregnancy with recession of virilism following excision of a thecoma in the puerperium. The masculinization syndrome has been reported [5, 8, 19] in association with ovarian enlargement and hyperplasia of the thecal cells, termed "hyperthecosis" by Fraenkel. In about 25 per cent of cases of thecoma there are no symptoms suggestive of endocrine dysfunction[3].

The treatment of thecoma consists simply in excision of the tumor which is curative except in the rare cases of malignant degeneration[7].

CASE REPORTS

The admission of three cases of thecoma in a period of three months prompted the following reports:

Case 1. Miss G. H., No. 16317, age 38, was admitted to the hospital on 22 December 1946 for study because of virilism. Hirsutism, coarseness of the voice and heavy frame had been present and increasing since the age of 16, just before the menarche. Her periods were irregular until the age of 35 when they became scantier and occurred every three weeks but the flow had become heavier again the year before admission. She had become pregnant in February 1946, and nearly three months later a Friedman test was negative. Following an induced abortion in the third month, she had a mild postabortal sepsis and resumed her menstrual cycle.

Examination showed a heavy-framed, broad-shouldered woman with bluish complexion and a beard requiring daily shaving. Coarse black hair was present on the shoulders, breast, abdomen and extremities. The clitoris was about 100% enlarged. The uterus was the size of a 2-3 months pregnancy. A rounded fist-sized tumor was detected to the right of the uterus. Basal metabolic rate was normal; pituitary fossa and peri-adrenal insufflation roentgen studies were negative. No studies were made for 17-ketosteroids in the urine.

At operation the right ovary was found to measure 6 x 5 x 3 cm., was irregularly ovoid, firm and pale pinkish-yellow and contained a 3 cm. cyst. This ovary and tube were removed. No left ovary was recognized. The uterus was about 25% enlarged.

On section the ovary was firm and fleshy; pale yellowish-pink tissue stroma composed the central portion whereas firm lemon yellow tissue divided into lobules by gray septa was found in a 5-14 mm. band beneath the serosa. One cyst contained hemorrhagic fluid and several smaller cysts contained pale yellow fluid. Uterine scrapings showed early secretory endometrium.

Microscopic examination of the yellowish tissue revealed elongated spindle-shaped cells forming interlacing bundles. The nuclei were rich in chromatin, elongated and spindle-shaped with little variation in size or staining quality, but there was some variation in the amount of eosinophilic substance in the cytoplasm. Fat stains showed a small amount of lipoid substance.

Diagnosis: Benign theca cell tumor of ovary.

Four months after operation she reported no menstrual flow. There was a visible decrease in the amount and coarseness of the hair of the face and body. The clitoris and uterus were unchanged. Estrogenic therapy was instituted.

Case 2. Mrs. M. D., No. 22284, age 46, was admitted to the hospital on 16 March 1947 because of menorrhagia. Her flow had increased seven years before admission and for four months she had flowed heavily two weeks in each month.

At the age of 16 her appendix was removed, and, at 42, she had a subtotal thyroidectomy for toxic nodular goiter. A mild hypertension had been present for several years.

Examination was not remarkable except for a multinodular uterus about three times normal in size. No adnexal tumor was recognized.

At operation the right ovary was found solidly enlarged to 6.5 x 5.5 x 4.7 cm. and was pale yellowish-pink. Supracervical hysterectomy and right salpingo-oophorectomy were performed.

On section the normal ovarian tissue was almost completely replaced by firm, smooth, orange-yellow, lobulated tissue with interspersed pinkish gray septa radiating from the hilum. The uterus measured 10 x 10 x 9 cm. and contained multiple fibromyomata.

Microscopic examination revealed many hyalinized areas but the yellow tissue noted on gross observation consisted of spindle-shaped, elongated cells with dark, ovoid nuclei and moderately distinct and abundant cytoplasm; the cells were arranged in crisscrossing bundles within a sparse connective tissue framework. Blood vessels were numerous. Occasional cells were round with laterally displaced nuclei and light staining cytoplasm. The endometrium was atrophic.

Diagnosis: Benign theca cell tumor of ovary.

Examination one month after operation revealed no abnormality.

Case 3*. Mrs. B. R., No. 21945, age 35, was admitted to the hospital on 27 February 1947 because of menorrhagia. Her periods were normal until age 21 when they became so irregular that she had one entire year of amenorrhea ten years before admission. She was treated by injections. For four to five years prior to entry she flowed two weeks each month, had cramps and noted pelvic pain on occasions. She had been unable to become pregnant.

At the age of 18 she had an abdominal operation with removal of the appendix and one tube.

Examination was not unusual except for slight uterine enlargement and a freely movable lemon-sized tumor in the left adnexae.

At operation the uterus was found normal; the left ovary was smooth and measured 6 x 4 cm.; the right ovary was enlarged to a lesser degree; adhesions were present throughout the pelvis. Both ovaries were removed.

The ovaries measured 6 x 3 x 4 cm. and 5.5 x 4 x 2.5 cm., were egg-shaped, firm, nodular, covered with yellowish pink serosa, and, on section demonstrated abundant yellowish pink lobulated stroma with several small cysts.

Microscopically there were areas of normal ovarian stroma, but the remainder was replaced by bundles of spindle-shaped cells with relatively large nuclei and relatively scanty eosinophilic cytoplasm; these cells were arranged in interlacing bundles not particularly

*Case 3 was a patient of Dr. R. J. McGann to whom the authors are indebted for the use of this report.

well demarcated from the adjoining less cellular and more hyalin stroma. The cysts were lined by a double layer of cuboidal cells.

Diagnosis: Benign theca cell tumor of ovaries.

Two months after operation she felt well, had no bleeding and was receiving estrogenic therapy.

DISCUSSION

In the first case roentgenograms after periadrenal air insufflation were negative. The partial recession of hirsutism following oophorectomy would appear to incriminate the thecoma as the cause. A paradox existed in that the most feminine of all characteristics, pregnancy, occurred in the presence of virilism; the negative Friedman test during the pregnancy may have been due to an abnormal level of androgen. Absence of the contralateral ovary with amenorrhea following unilateral oophorectomy suggests that it is possible for ovulation to occur in the ovary involved by the tumor.

The second case is characteristic of the symtoms of the majority of reported cases of thecoma and confirms the incidence of associated fibromyoma.

Similar symptoms were present in the third case, but we have been unable to find a report of bilateral thecoma and consider that this case may be unique. To be sure, bilateral thecal hyperplasia has been reported[8], but generally in association with the masculinization syndrome.

CONCLUSIONS

Thecoma is a functioning ovarian neoplasm of mesenchymogenic origin common also to granulosa cell tumor. It is possible that the presence of granulosa cells in thecoma is responsible for symptoms attributable to estrogenic production. Nevertheless, there appears to be a relationship between thecoma and the masculinizing ovarian tumors, probably based on similarities in the lipoid containing cells. Despite these morphologic similarities, certain characteristics of thecoma such as the usual age incidence, the gross charcteristics, and the infrequent occurrence of malignancy, are of clinical importance.

SUMMARY

A genetic relationship between the functioning ovarian tumors appears to be established. Admixtures and gradations of type are common. Theca cell tumor is probably related to granulosa cell tumor.

Three cases of so-called "thecoma" with varying symptomatology are presented.

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DISCUSSION

Dr. Ronald R. Greene, Chicago: We all owe thanks to Drs. Patton for an unusually excellent presentation of a relatively new and what should be a somewhat controversial subject.

Loeffler and Priesel almost universally have been given credit, or should it be blame, for first describing these tumors in 1932, though Moretti and Arrigoni clearly described them in 1927. To date approximately 100 have been reported. Most of them have been found because old tissues diagnosed as fibromata have been re-examined. No matter what the findings have been a diagnosis of theca cell tumor was made. Cases 2 and 3 are quite characteristic, both grossly and microscopically.

I am going to disagree with the authors about Case 1. Through sheer coincidence I saw the microscopic preparations of Case 1 which were sent to Dr. George H. Gardner, who is one of the members of the Board of the Tumor Registry of the American Gynecological Society. I spent some time studying the microscopic preparations of this case and I do not believe the patient had an actual tumor, for several reasons. First, the size was given as approximately twice that of a normal ovary. The patient apparently had, and had always had an aplasia or lack of development of the left ovary. The right ovary, therefore, carried on the function of both ovaries. This is a compensatory or physiological hypertrophy, the same as occurs when one adrenal gland is removed. The measurement of the ovary according to Maximoff is from 2.5x1.5x0.6 to 5.0x3x1.5 cm. The size of this ovary by compensatory hypertrophy could easily be the reported 6x5x3.

Secondly, microscopically there was no demarcation, between what was considered ovarian tissue and the rest of the cortical and medullary stroma of this ovary. There was no gradation stroma of the tumor or areas in the slides contain primordial follicles, mature follicles and atretic follicles. There were no interstitial cells. The stroma was identical to that found in properly fixed, properly prepared ovarian stroma. From the photograph it was obviously a hemorrhagic, cystic corpus luteum.

Third, hormonically — the masculization dates back to the age of sixteen. She was operated on at 38 years. There is little likelihood of the tumor being present for twenty-two years without symptoms. I know it is reported and it is probably possible but it always seems unlikely that a tumor producing hormone in excessive amounts would not destroy the ovary. It is hard to conceive of sufficient caliber of the remaining ovary to produce mature follicles resulting in pregnancy.

Dr. Robert J. Patton, Springfield (closing): I am delighted that Dr. Greene brought up some controversial points. We relied not only on our own pathologist in whom we have a great deal of confidence, but sent the slides to the ovarian tumor registry hoping they would confirm the opinion. We have heard from Dr. Emil Novak who says it is a thecoma. I believe it is a thecoma because it had the characteristic yellowish appearance. I am sorry I could not show it in color. There were areas of normal ovarian tissue in the center. There is no question but up under the cortex there was a band as wide as your finger of lobulated yellow tissue which was distinctly different from the normal ovary. I still feel it is a thecoma, although from reading the various reports of thecoma I wondered somewhat if there is not much more thecal hyperplasia than we really know about. Our pathologist said that perhaps that third case was not what is really thecal hyperplasia although there were yellowish elements.

MORTALITY FROM GALLSTONES DECLINES

According to the Statistical Bulletin of the Metropolitan Life Insurance Company, the age adjusted death rate from gallstones among white policy holders (ages 1 to 74 years) dropped from 3.4 per 100,000 in 1936 to 1.7 per 100,000 in 1946, a reduction of 50 per cent. For at least fifty years prior to 1936, however, the death rate from this cause showed no improvement.

The recent decline benefited policyholders in each sex and at every age period of adult life; prior to age 35 the death rate from gallstones is pratically negligible. The decrease in mortality was larger for women than for men throughout adult life. Nevertheless, the death rate among women is still more than twice that for men at almost every age period.

Undoubtedly, a substantial part of the recent reduction in the mortality from gallstones is to be credited to the widespread use of the sulfa drugs and pencillin in combating infections which may seriously complicate the original condition. At the same time there have also been advances in surgical techniques.

Laboratory Methods Useful in the Differential Diagnosis of Chronic Chest Diseases

Henry C. Sweany, M.D. and J. Robert Thompson, M.D.
Chicago

In discussing laboratory methods of value in the differential diagnosis of chronic chest diseases, one should keep within the realm of practicality and consider only those procedures which the ordinary laboratory can perform. Many laboratories lack the personnel and equipment to conduct tests we consider practical, and until such a time as they are equipped the clinician will be handicapped in his efforts. In turn, the physician can be of great help to the laboratory if he will plan his program of investigation by cooperating with the technical staff.

Every precaution must be taken when collecting specimens for analysis, making sure that fluids or tissues are placed in sterile containers or in the proper fixative. The interval between the time of collecting samples and their arrival at the laboratory should be minimal. If a sputum is to be submitted, instruct the patient as to the method of securing it, advising the patient to collect only that brought up after coughing or from the "depths" of the chest. The attending doctor would do well to note the physical characteristics of material he collects (pleural fluid, sputum, tissue, etc.) at the time it is taken and pass this information to the laboratory workers. It cannot be emphasized too strongly that careful planning of the various procedures contemplated will save time for the doctor, patient and laboratory worker; the financial aspect, in respect to the patient, must be considered also.

From the Research Laboratories of the City of Chicago Municipal Tuberculosis Sanitarium.

Read before General Assembly, Illinois State Medical Society, May 14, 1947, Chicago.

With this introduction we will discuss briefly several of the more important and essential laboratory procedures (x-rays will not be included).

I. *Blood examination.*

A. *Sedimentation rate* — while considered by some to be of doubtful value because of the number of variables involved, it is commonly used and rather simple to do. In general it is considered to be an indication of protein variability (especially the fibrinogen fraction) and an index of the degree of inflammation in the body.[1] In tuberculosis, the speed of sedimentation parallels the activity of the disease; in cancer, it closely parallels the degree of malignancy; and in localized acute inflammations, the rate increases in direct proportion to the leucocyte count.[2]

B. *Protein content* — early cases of sarcoidosis (Boeck) usually show a marked increase in globulin fraction (gamma) and an increase in the total protein. All stages of tuberculosis show an increase in the globulin fraction, a decrease in the albumin fraction and a normal or subnormal total protein. The usual picture in cancer is a slight increase in the globulin fraction (alpha) but a decrease in the total protein.[3]

C. *Differential blood count* is a routine laboratory procedure in most hospitals. Especially one should look for eosinophiles in numbers above normal in allergic conditions; immature leukocytes in infectious processes; and abnormal cells in suspected blood dyscrasias. The presence of toxic granules in the poly-

morphonuclears leukocytes are of significance also.

D. *Wassermann or Kahn test* — is of course a routine procedure. Aortic aneurysms and gummata must be considered in the differential diagnosis of chronic chest diseases.

II. *Bacterial cultures* should be made from sputum, stomach lavage, pleural fluid and brochial aspirations, as well as from tissue obtained by biopsy method (lymph nodes, needle punctures, skin, etc.).

A. *Isolation of tubercle bacilli* — at one time considered a difficult procedure, can now be done with relative ease. Approximately 10 per cent more positives can be found by culture than with concentration smear and animal inoculation. Last year Dubos and Davis reported the use of Tween 80, a water-soluble ester of a fatty acid (Oleic) in combination with bovine plasma in a liquid medium for more rapid growth of tubercle bacilli.[4] In our own laboratory we have incorporated Tween 80 and bovine plasma in one of the basal solid media (Saenz' or Loewenstein's)[5] and obtained growth more rapidly than with the basal media alone; using this technique it is not unusual to have luxuriant growth three weeks after inoculation.

B. Because of the incidence of *mycotic infection* the laboratory should attempt isolation of any related organisms. Inoculation of any one of several media (such as Sabouraud's) should be ample.

C. Needless to say, aerobic and anaerobic cultures for other microorganisms in chronic suppurative disease of the lungs is indicated. It is a mistake and impractical to assume that a fully trained bacteriologist is essential to carry out these procedures. Most media are sold commercially and the others can be easily prepared. An alert technician can be relied upon to make any cultures and if necessary consult a qualified bacteriologist when specific problems arise.

III. *Animal inoculation* — the same materials which are cultured should be injected into a laboratory animal. The two animals of greatest value for the average laboratory are the guinea pig and the white mouse. The hamster was reputed to be of greater value for tuberculosis work because of the shorter length of time required to develop lesions, but in our work we have found the guinea pig more reliable and easier to care for. The white mouse is used for toxicity studies on organisms isolated from chronic suppurative disease of the lungs.

IV. *Micro-sections* —

A. *Sputum, bronchial aspirations* and *pleural fluid* lend themselves very well to sectioning. Our method is to fix in formalin, centrifuge at high speed, and carry the precipitated material through the solutions as we would a piece of tissue. About one year ago Papanicolaou (6) reported several cases in which he used a method like that used in diagnosing cervical carcinoma by vaginal smears. This method involves the use of special stains which theoretically make the abnormal cells more easily identified. Suffice it to say that each technique has its merits and the important point is that the microscopist learn to identify normal and abnormal cells which comprise the sputum or pleural fluid flora.

B. *Lymph node* — an intensive search for lymph nodes which can be removed for microscopic study should be carried out. This is of value especially in tuberculosis, cancer, histoplasmosis and the malignant lymphomas.

C. *Skin* — the lesions in Boeck's sarcoid are rather characteristic and the microscopic picture is rather typical; other diseases such as disseminated lupus and blastomycosis show skin lesions which can be biopsied readily.

D. *Sternal marrow* biopsies have been reported to be of value in diagnosing miliary tuberculosis; for this procedure a good core of bone marrow must be obtained.

E. *Needle biopsies* of parenchymal lesions or masses in the chest are not without inherent dangers.

V. *Skin testing* —

A. *Tuberculin* (Old Tuberculin) in varying dilutions beginning with 0.1 cc. of a 1:10,000 strength and running down to a 1:10 dilution is of value. A positive reaction signifies hypersensitivity through infection or vaccination but does not indicate the degree of activity. A strongly positive reaction in the 1:10,000 dilution in young adults is good evidence of active tuberculosis. Negative tuberculin reactions have a greater absolute value than

positive reactions; in completely insensitive cases where there is not sufficient evidence to explain the decrease in sensitivity (as overwhelming disease) the individual is practically never tuberculous.[7]

B. *Histoplasmin* — skin test should be done in suspected cases. A great deal has been written on healed pulmonary lesions (calcifications) in tuberculin-negative students in the Kansas City area.[8] These individuals were positve to histoplasmin. There is at present a paucity of anatomical-pathological evidence to substantiate the claims that these are healed histoplasmosis cases.

C. *Coccidioidin* — is another skin test at our disposal. When dealing with an asthmatic, bronchiectatic or bronchitic patient, a complete series of skin tests is indicated to establish whether or not there is any sensitivity to *pollens, dusts, foods, clothing,* etc.

In conclusion, we might stress that each patient offers a different problem as to the number and nature of the laboratory tests to be done. Through cooperative effort on the part of the clinician and the laboratory, most of the pitfalls can be avoided. Information helpful in arriving at the correct clinical diagnosis will then be forthcoming.

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SOMETHING CAN BE DONE

In one respect Geriatrics is making signficant and notable advance. Because a disease is incurable, or a deterioration irreversible, the idea that the doctor can do nothing, would be regarded in the future as a betrayal of the standards of the medical profession and the interests of the patient. Faced with any incurable or any of the normal deterioration of aging, the physician works for three things: alleviation, palliation and postponement. His method is characteristically one of support. For example, if a heart condition is incurable he will bring all the other organs, nutritional resources and hygiene program of the patient up to the highest efficiency. This gives the heart better service and less labor and also may remove one or more of the original and continuing causes of cardiac condition.

This gives the heart a chance to return to the organs longer and better service than before. The man is better, the heart is better. Many a man has become more active, more vigorous and happier after his first coronary attack by the use of this method. If one cannot restore the crippled organ, restore the man, he may "cure" his own heart. This is typical of the direction of advance in Geriatrics. It applies to every organ and function.

Much can be done for the weakened or diseased and otherwise hopeless kidney, liver, pancreas, eye, joints, arteries and the mind of the ageing man by this procedure. Research is increasingly bringing out the fact that the illness of one organ is often due to failure of another and this in turn the result of yet a cause still more occult. This points to the importance of a thorough all-over examination of the whole patient in the presence of any chronic illness and also in the presence, of no apparent illness at all.—C. Ward Crampton M.D., in *Bull. Med. Soc. Co. of Kings.*

CASE REPORTS



Appendiceal Lithiasis

Benjamin F. Hoopes, M.D., F.A.C.S.
Bloomington, Illinois

A calcified fecalith of the appendix may present a difficult differential diagnosis for the radiologist.[1,2,3,4,5,6,7,8] The pathological conditions which offer the most difficulty are phleboliths, calified mesenteric nodes, enteroliths of the bowel, gall stones and ureteral stones. Phleboliths are most commonly multiple and bilateral. They lie deep in the pelvis and appear circular with a smooth surface. Calcified glands are usually near the spine. Enteroliths in the bowel are usually larger and movable. Gall stones are less dense and, as a rule, higher in the abdomen. They may be visualized by cholecystography. Ureteral calculi are frequently smaller in size, lie in the course of the ureter and may be diagnosed by passing a ureteral catheter.

The following case is presented, as the calculi were faceted and of the shape and size of those commonly found in the gall bladder.

J. K. S. 18 year old sailor. The patient first noted generalized abdominal pain and nausea about 24 hours before admission to the hospital. He developed diarrhea and had five loose stools that contained neither blood nor mucous. The pain continued and localized in the right lower quadrent of the abdomen. No nausea or vomiting was present. The past history and family history were irrelevent. A review of systems revealed no other complaints. Physical examination. T.100. P.90, R 20, BP 120/56. Head and neck, negative. Lungs, clear to percussion and auscultation. Heart, no murmurs or enlargement. Abdomen, tenderness in the right lower quadrent over McBurney's point. Spasm of the adominal muscles. Moderate rebound tenderness was present. Genitalia were normal and there were no herniae. Rectal examination, there was tenderness on the right, but no mass was felt. Laboratory examination. Blood, Wbc 16,000. Pmn; 90% segmented forms, 1% nonsegmented; 9% lymphocytes. Kahn test negative. Urine: Sp. Gr. 1.022. Albumin and sugar negative. Microscopic examination: occasional leucocyte, no red blood cells.

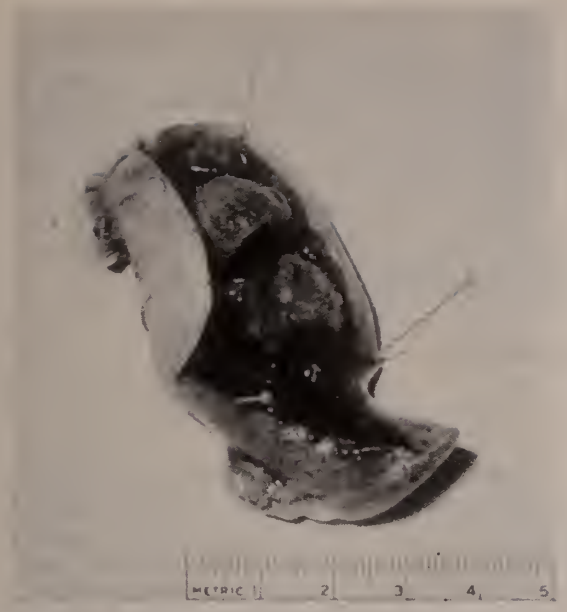


Figure 1. Photographs of the surgicol specimen, showing the two foceted stones in the proximol portion of the oppendix.

Operation. An appendectomy was performed through a McBurney incision. The appendix was acutely inflamed in the distal one-half. The proximal half was hard and tense. The appendix was removed without difficulty. Pathological findings. The specimen consisted of a large swollen appendix which measured 8 cm. in length and 2 cm. in its greatest diameter. The serosal vessels were injected throughout and the terminal portion appeared acutely inflammed. Upon opening the appendix the proximal had contained two faceted brown calculi (Figure 1). Each calculus measured 1 cm. in diameter. They were quite hard and when sectioned the calculi appeared to be laminated. This characteristic could also be seen in an x-ray of the calculi (Figure 2). The center of each contained fecal material. On drying, the calculi changed from a dark brown to white. Analysis showed the calculi to contain calcium phosphate. Microscopic examination of the sections of the appendix showed an acute inflammatory process in the distal one-half.

DISCUSSION

In addition to the difficulty in diagnosis that may be occasioned by a calculus in the appendix, one may also have post operative complications caused by the presence of the foreign body. The two most common complications are rupture of the appendix, allowing the calculus to enter the peritoneal cavity[9] and a draining sinus tract to the appendix.[10,11]

In the case presented, no difficulty in diagnosis was encountered as the history and physical findings suggested acute appendicitis. The two calculi in the appendix were incidental findings at the time of operation. No complications resulted.

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Figure 2. Three x-roys of the surgical specimens. These show the lomination of the colculi os well os their shape ond size on on x-ray plate.

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It is wise to assume that all subjects who show a positive tuberculin test before the age of three years have active infection. In such children, the infection has hardly had time to become inactive. Joseph D. Wassersug, M.D., N.E. Jour. Med., July 3, 1947.

In regions where histoplasmin sensitivity is widespread, pulmonary infiltrations as well as calcifications are frequently nontuberculous, and can be differentiated from tuberculosis only by skin tests at present. Michael L. Furcolow, M.D., Herbert L. Mantz, M.D. and Ira Lewis, M.D., Pub. Health Rep., Dec. 5, 1947.

A hospital would not fail to provide a patient with a routine urinalysis and yet it is stated that only 0.4 per cent of cases of diabetes are discovered by such a routine procedure. The amount of significant tuberculosis discovered by providing a routine x-ray is much larger. It is also said that less than 1 per cent of patients provided a routine blood count have a blood dyscrasia. Less syphilis is found by providing routine Wassermanns than significant tuberculosis by providing a routine chest x-ray. Allan Filek, M.D., 1947 Trans., NTA.

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INDUSTRIAL HEALTH



Occupational Disease in Differential Diagnosis

H. T. Castberg, M.D.—USPHS

A patient's occupation is frequently a significant clue to his physical condition. A knowledge of his work and work history and the materials to which he is or has been exposed may be all important in the differential diagnosis of an illness.

To obtain information concerning these factors, a careful occupational history must be a part of the present and past medical history. The occupational history must be detailed and include the patient's total work history. Not only is the present work important but information must be obtained of all his previous jobs back to the time he left school or took his first job.

From experience it has been found that it is better to obtain information concerning the present work first. Most persons are able to give data concerning their present occupation in more detail and more accurately than they can for previous occupations.

Next, information is obtained concerning the previous job. Each previous employment is then investgated and recorded in reverse chronological order.

It is more logical to ask a person, "What is your present work, what do you do now?" than to ask him immediately to recall work he did several years ago. He is much more likely to remember details of employment in previous jobs after he has talked about the more recent one.

When an occupational history is being taken, it is useless, many times, to learn merely the name of the job. If a man says he is a molder in a foundry, it has no significance unless the physician is acquainted with the work of a molder and knows what the specific conditions are surrounding that particular job.

In obtaining an occupational history, the purpose is to discover what in the working environment will affect the health of the worker. It is important to learn (1) the number of years or months spent at each occupation; (2) the hazardous materials in the form of dusts, fumes, gases and vapors, with which he works; (3) the concentrations of these materials in the atmo-

sphere; (4) the length of time of exposure to these materials each day; (5) if there is exposure to excessive noise, heat, glare, ultraviolet rays, radium or x-ray; and (6) what control measures are used to reduce or eliminate exposure, and are these protective measures effective.

All of these items are important in evaluating the significance of an occupational exposure. For example, serious illness can be produced by exposure to lead compounds in the manufacture of storage batteries. Work with the dust of lead compounds when uncontrolled by protective measures such as local exhaust ventilation is very hazardous. However, the same job, when proper local exhaust ventilation is provided is perfectly safe. Similarly, even if local exhaust ventilation is provided, the job is not safe unless the ventilation equipment is in proper working order and is doing the job it is designed to do.

Every physician cannot visit the plant where each patient works, but in many instances such visits are extremely valuable. Certainly, if there is some doubt about occupational origin of an illness, such a plant visit is essential. In addition to the plant visit it is sometimes necessary to obtain information on the concentration of a hazardous dust fume, gas, or vapor in the workroom atmosphere. This information can only be obtained by proper industrial hygiene air sampling procedures. In many instances the information may not be available from the plant but the State or local industrial hygiene division may have it. If the work has not actually been done in the particular plant the industrial hygiene division should be able to provide this information after a study of the plan has been completed.

According to occupational disease reports received by health departments it is apparent that too often physicians handle occupational diseases in a much too empirical fashion. If the patient indicates that he is working with lead compounds the diagnosis is much too frequently given as lead poisoning without adequate investigation or study.

It is probably understandable why incompetence exists in connection with occupational disease diagnosis. One reason is that very little attention is given to occupational diseases in medical education. Another is the fact that in past the usual practicing physician only occasionally was confronted with an industrial case of this type and therefore takes little specific interest in it. But now the average physician sees many more cases of occupational origin because of industrialization of almost all sections of the country. Therefore it is important that every physician understand the diseases which can be produced by industrial exposures.

The diagnosis of these diseases is not much different from the diagnosis of other diseases of nonoccupational origin. Each toxic substance used in industry has a specific action on the internal organs or systems and presents specific symptom complexes and signs which are known. To be sure, there are many new materials which are used in industry whose effects are not as yet well known. However, work is constantly being done by research groups to give us that information.

A large heavy exposure to benzol will produce symptoms and signs of neurological origin while long standing "chronic" exposure will cause probably none of the neurological symptoms but will produce definite hematopoietic effects such as anemia and an aplastic blood picture.

PROBLEMS IN DIFFERENTIAL DIAGNOSIS

It is interesting and informative to notice how materials which cause occupational diseases produce symptoms and signs very similar to other diseases of non-occupational origin and must be considered in any differential diagnosis.

Blood.—Stippled cells, for instance, are found in exposures to lead, arsenic, mercury, aniline and nitrobenzene, but are also found in the blood of patients with any disease causing destruction of red blood cells, such as many anemias and leukemias.

The blood may exhibit the picture normally associated with aplastic anemias from excessive "chronic" exposure to benzol. This is an extremely toxic material which is used in many industrial processes. Exposure to radium, x-rays, and gamma rays by action on the system may produce a similar picture.

Polycythemia may be present from exposure over an extended period of time to industrial hazards which cause inadequate oxygen supply, such as carbon monoxide, the cyanides, lowered oxygen tension, as well as cobalt. The nonoccupational diseases which must be differentiated on the basis of this finding alone are polycythemia vera, effects of high altitude, and certain chronic cariac and pulmonary disease.

Nervous System.—One of the classical signs

of lead poisoning is wrist drop or ankle drop. If a patient exhibits this sign the cause must be differentiated from musculospiral nerve paralysis or peroneal nerve paralysis which can be produced by other nonoccupational causes such as trauma or tumor.

Tremor is a common sign which is seen in hyperthyroidism, parkinsonism, and senilty. But it is also an extremely important sign when associated with other symptoms and signs in mercurialism and manganese and carbon disulphide poisoning.

Manganese can produce gait disturbances and other neurological signs which may be indistinguishable in themselves from tables dorsalis or multiple sclerosis.

Severe character changes can be produced by manganese, such as scanning speech or marked irritability, irascibility and extreme nervousness by mercury or carbon disulphide exposure. Even psychoses are produced by such industrial poisons as carbon disulphide. Mercurialism is almost indistinguishable from hyperthyroidism.

Exposures to such solvents as trichlorethylene, carbon tetrachloride and others have a narcotic action similar to alcohol. Cases have been reported in which workmen have been arrested for drunkenness when the worst that has happened was that they had been working over a degreasing tank of trichlorethylene.

Severe encephalitis can be produced by heavy exposure to lead which is indistinguishable from other encephalopathies.

Lungs.—The differential diagnosis of pulmonary disorders causes perhaps most difficulty. Pneumoconioses in various stages or from different causes have varying X-rays appearances. They can be easily confused with such infectious diseases as tuberculosis, mycotic pulmonary infections and pneumonia.

Mitral stenosis exhibits an appearance on chest X-ray similar to early silicosis or abestosis. Miliary tuberculosis can be confused with nodular silicosis or siderosis. The nodulocongloмerate fibrosis of advanced silicosis may be mistaken for malignant tumors.

Liver Damage.—Liver damage is a result of systemic poisoning from such industrial materials as the chlorinated hydrocarbons of these solvents. Carbon tetrachchloride is perhaps the most commonly encountered. It is amazing when the toxic properties are so well known that it is used in many industrial plants with no regard to its potential hazard. There are many prepartions used industrially which contain carbon tetrachloride mainly to reduce flammability; its presence, however, is not generally made known.

The chlorinated diphenyls and naphthalenes which are used as dielectics also cause liver damage when systemic poisoning occurs from them. In severe cases these will manifest themselves by causing jaundice or high icteric indexes but may be detected by other means when the damage is less severe. In these instances a knowledge of exposure is essential for differential diagnosis from other disease such as infections hepatitis or cholelithiasis and thus to prevent errors in diagnosis and treatment.

Kidney Damage.—Kidney damage is a common result of industrial intoxication and must be differentiated from kidney damage from other causes, such as Bright's disease and urinary infections. Poisoning from chlorinated hydrocarbons, many of the metals and many other industrial substances cause the appearance in the urine of albumen, casts, red cells, and other products which indicate kidney damage.

Skin.—The dermatitis of industry is practically synonymous with contact dermatitis. Most of the dermatoses which develop in industry are the result of contact with either primary irritants or sensitizers. The cause of these dermatoses must be determined in order to effect a cure. Since, in most intances, the most important means of curing a contact dermatitis is removal of the patient from the cause, it is obviously extremely important to know whether the dermatitis is caused by some irritant in the patient's working environment or his home.

Acne, for instance, may be merely acne vulgaris which has no industrial cause. But if it is found on the arms or ventral surfaces of the thighs, where oil can come in contact with the skin, the chances are that it is industrial.

The chlorinated diphenyls and naphthalenes produce in persons exposed to them chloracne which may be confused at times with acne vulgaris. This, however, is an entirely different type of skin reaction which requires different treatment.

One of the commonest errors in dermatitis cases is the mistaken identification of industrial contact dermatitis and the subequent over-treatment which is so frequently given. As was men-

tioned before, the best cure is removal from the cause followed by bland soothing treatment. Frequently, the dermatitis persists and is made worse by the intensive treatment given.

Mouth and Teeth.—The mouth is frequently a site for early recognition of effect from occupational hazards. Stomatitis and excessive salivation are early signs of mercurial poisoning. If the physician does not learn from the patient's occupational history that there is an exposure to mercury in his work the condition might well be and frequently is treated is an infection or nutritional deficiency.

The metallic line which appears on the gingival margins is commonly an early sign of plumbism, but it may also be an indication of extensive treatment with bismuth compounds. It is important to learn the cause.

Workmen exposed to high concentrations of acids in their working environment develop characteristic tooth erosions and caries. These must be differentiated from caries from other causes.

Eyes and Nose.—Cataracts may result from occupational exposures. Thus, glass blowers after some years' exposure to the red glowing glass have been known to develop cataracts and must be distinguished from other causes of cataract.

Ultraviolet rays cause severe conjunctivitis with marked photophobia and edema. This must be distinguished from other types in order to give proper treatment. This can only be done by investigating the patient's work.

Perforated nasal septum is a common result of exposure to dichromate mists in an occupation such as electroplating, or from exposure to certain arsenic compounds. It is unfortunate to suspect syphilis when a perforated septum is found which is caused by an industrial exposure.

Abdominal Colic.—One of the symptoms which has caused more confusion than many others is the abdominal colic produced by exacerbations of acute lead poisoning. There have been an unfortunately large number of patients who have been subjected to abdominal surgery for appendectomy which was absolutely unnecessary. If the surgeon had inquired into the occupational history and made a few laboratory tests it would have been obvious that the condition was not appendicitis but lead colic.

These examples emphasize again the importance of learning from the patient the work he does and the materials with which he works.

Unless such a comprehensive history is obtained, erroneous diagnostic assumptions will be almost unavoidable.[1]

Industrial Hygiene Newsletter, June 1948

[1]R. T. Johnstone, Industrial Medicine and Industrial Hygiene, Mosbys, St. Louis, 1947.

ON BEING A COMMITTEE MEMBER

It might be interesting to consider the ideal member of a committee. What are his qualifications, and how does he meet his responsibilities?

First, he should have the interests of the medical profession at heart.

Second, he will give thought and study to the subjects which come up before the committee and will not be just one of those present.

Third, he will make it a point to be on hand for all meetings, unless his professional duties require him to be elsewhere.

Fourth, he will not allow one or two men to assume the entire burden for developing plans, but will contribute ideas of his own.

Fifth, he will do what he can to make the meeting orderly and not overlong.— From *Medical Annals,* District of Columbia.

NEWS OF THE STATE



ADAMS

Ninety Years of Age.—Dr. E. B. Montgomery, Quincy, observed his ninetieth birthday, May 11. Still active, Dr. Montgomery has practiced medicine for seventy years in Quincy. He is said to be the oldest member of the Adams County Medical Society.

Walter Stevenson Honored.—Dr. Walter D. Stevenson, Quincy, President-Elect of the Illinois State Medical Society, was guest of honor at a dinner given by the Adams County Medical Society at the Hotel Lincoln-Douglas, July 10. Included among the eighty-two persons present were Drs. F. Garm Norbury, Jacksonville, Councilor of the Sixth District, Illinois State Medical Society, and Dr. G. C. Otrich, Belleville, Councilor of the Tenth District. Dr. Stevenson, who has served as councilor for the Sixth District and as Chairman of the Council of the Illinois State Medical Society, was presented with a scroll and a silver bowl. The scroll, signed by the seventy-one members of the county medical society was inscribed in part: "This scroll is presented to you by the Adams County Medical Society in recognition of your meritorious service to the society of which you are a member. We wish you continued success as president of the Illinois State Medical Society. You are richly deserving of the honor." Dr. Newton DePu was chairman of the Committee on Arrangements for the occasion, according to the Quincy Herald-Whig.

CLAY

Ground Breaking Ceremonies.—Ceremonies were held recently to break the ground for the new Clay County Hospital. Included among the speakers at the ceremony were Dr. Joseph Mountin, U. S. Public Health Service, Dr. N. W. Bowman, Flora, and Dr. Roland R. Cross, state director of public health and Dr. Henrietta Herbolsheimer, both of Springfield.

COOK

Council on Rheumatic Fever.—The Council on Rheumatic Fever of the Chicago Heart Association has been organized for the purpose of promoting and coordinating the study, prevention, and treatment of rheumatic fever and rheumatic heart disease in the Chicago area. The Council will consist of representatives of community organizations concerned with the rheumatic fever problem and will function as a division of the Chicago Heart Association. Dr. Stanley Gibson has been elected chairman of the Council, with Dr. H. William Elghammer vice chairman and Miss Elsa Eisendrath as secretary. The Executive Commitee is as follows: Drs. Henry G. Poncher, chairman, Stanley Gibson, Robert A. Black, Jesse Hofer, Louis N. Katz, Philip Rosenblum, G. K. Fenn (ex-officio) and Mrs. R. P. Mc Eldowney (ex-officio).

Society News.—Robert S. Berghoff will be the principal speaker at the Rotary Club, October 21, at the Hotel Sherman. His subject will be "The Business Man and His Heart".—Dr. C. O. Sappington, Chicago, addressed the general assembly of the Canadian Medical Association, June 25, in Toronto, on "Modern Methods of Health Protection in Industry" and "Prevailing Practices in Industrial Health Programs".—Dr. M. A. Pertein discussed "Education of the Cerebral Palsied Child" before the Third Annual Conference on the Education of Exceptional Children at the Illinois State Normal University, Normal, on July 28.

Appointments at Loyola.—Included among recent appointments to the Stritch School of Medicine of Loyola University are the following: Elinar Leifson, Ph.D., formerly of Baltimore, chairman of the department of bacteriology; Martin B. Williamson, Ph.D., Boston, assistant professor of biochemistry; Leslie A. Emmert, B.A., and Harold D. Fish, M.S., department of anatomy; Dr. Rocco V. Serritella and Dr. Edward T. Wilson, department of urology; Drs. John M. Dudek, Gould A. Andrews Jr., Albert G. Denten, Charles W. Pfister and Walter J. Kawula, department of medicine; Dr. George T. Stanton, department of neuropsychiatry; and Dr. Frederick R. Schwartz, department of dermatology.

Poliomyelitis Team Available for Assistance.—The Northwestern University Medical School's poliomyelitis team, headed by Dr. Emil D. W. Hauser, assistant professor of bone and joint surgery, is on call to aid poliomyelitis-stricken communities anywhere in the United States. The crew is assigned to duty and its expenses paid by the National Foundation for Infantile Paralysis. This is the crew's fourth summer of duty. Last year it served in Boise, Idaho, and before that in Rockford and Peoria, Ill. Its functions include medical consultation to doctors of the community, teaching local hospital nurses bed posture for patients and the administration of hot packs; instruction in physical therapy technics of muscle reeducation, and general functional exercises. The crew is prepared to stay on duty up to six weeks until its work in organization, teaching and medical assistance is completed. After that, the assistant orthopedist in the team remains in the stricken community as long as he is needed. Members of the 1948 team, in addition to Dr. Hauser, are Dr. Arthur F. Abt, associate professor of pediatrics; Dr. Erwin J. Cummins, orthopedist; Miss Meredith Nordschow, instructor in physical medicine; Miss Ann Prochaska, chief physical therapist, and the Misses Bernice Gotaas and Lucille Kurzawa, physical therapists. The other three teams operating under the National Foundation are those at Stanford and Harvard Universities, and the D. T. Watson School of Physical Therapy, Leetsdale, Pa.

Dr. Grulee Gives Library to Crerar.—Dr. Clifford G. Grulee, Evanston, Secretary of the American Academy of Pediatrics, and prominent peditrician, has donated his personal collection of books on children's disease to the John Crerar Library. Centerpiece of the rare volume part of the gift, consisting of some 300 works in Latin, German, French, Italian and other languages is a parchment bound volume of "Libellum de Egritudinibus Infantium" (Booklet on the Illnesses of Infants), by Paulus Bagellardus de Flumine, published in 1472. One of five known copies in the United States, it is the progenitor of all books on pediatrics and perhaps of all medical volumes, the Chicago Tribune reported.

Promotions at Illinois.—Included among recent promotions at the University of Illinois College of Medicine are: Dr. Cecil A. Krakower, professor of pathology. He also will serve as associate pathologist in the University's 428-bed research and educational hospitals; Dr. F. H. Squire, clinical professor of radiology (Rush). He has been a member of the University faculty since 1941, and served for a time as acting head of the department of radiology.

The rank of associate professor has been given to Dr. M. I. Grossman, in physiology, and Dr. Georgiana Theobald, in ophthalmology. Dr. Grossman is conducting research in physiology with special emphasis upon physiology of the gastrointestinal tract, and is author or co-author of more than 70 papers in that field. Dr. Theobald's research activities have involved anatomical studies of the canal schlemm of the eye.

Assistant professorships have been awarded to four. They are Dr. M. J. Brunner, dermatology; Dr. H. R. Catchpole, physiology; Miss Ruth Coleman, medical illustration; and Dr. J. S. Haas, ophthalmology.

Gift to Northwestern.—A gift of $70,000 to Northwestern University from Sterling Morton of Lake Forest, chairman of the board of the Morton Salt Company, was recently announced.

Mr. Morton, who is past president of the Illinois Manufacturers Association, placed no restriction on the gift. It is expected that the trustees will add the sum to the fund of more than $2,000,000 bequeathed to Northwestern in 1940 by Mr. Morton's stepmother, the late Mrs. Joy Morton.

Terms of Mrs. Morton's will provided that the bequest be used for medical research and for the erection and endowment of the Morton Memorial Hospital, which the University plans to build as a unit of its developing medical center on the Chicago campus. Construction of the hospital has been delayed by abnormally high building costs.

Specialty Society Election.—At the annual meeting of the Chicago Gynecological Society, June 18, 1948, the following officers were elected: Drs. Herbert E. Schmitz, president; Eugene A. Edwards, president-elect; John I. Brewer, vice-president; Edward M. Dorr, secretary; Fred O. Priest,, treasurer; William G. Cummings, pathologist; and Edwin J. De Costa, editor.

Grants for Research.—Recent grants to the University of Illinois include the following: By the National Foundation for Infantile Paralysis, Inc., $4,695 to the University of Illinois College of Medicine for the purpose of completing a program of research to evaluate a new muscle stimulator as a means of treating poliomyelitis, $12,000 to the Division of Services for Crippled Children for making a recording of a film on poliomyelitis, and $6,080 to the College of Medicine for studies in electrical stimulation of muscles of poliomyelitis patients and electromyographic studies of poliomyelitis patients; by the American Cancer Society, $18,935 to the College of Medicine in support of cytochemical

studies of relations between nucleus and cytoplasm; by Mead Johnson and Company, $7,000 to the College of Medicine to support fellowship in research in biochemistry in the department of pediatrics; and by the family of the late Mrs. Margaret A. Gruber, Chicago, $400 to the University of Illinois Hospitals for research into the causes and cure of leukemia.

Loyola University Receives Million Dollar Gift.—At the opening of Loyola University's medical-dental school drive June 15 at the Stevens Hotel, the university received a $1,000,000 gift from Frank J. Lewis, Chicago industrialist. Mr. Lewis' gift will be used to establish a trust which is expected to yield $50,000 a year for the medical school's operating expenses. He has also donated the site for the university's proposed Stritch School of Medicine in the west side medical center.

DU PAGE

Personal.—Dr. E. H. Kupke, Naperville, was recently elected a director and member of the governing board of the Du Page County Family Service Association. Dr. Kupke is president of the Du Page County Medical Society.

FRANKLIN

Personal.—Dr. R. C. Steck, Christopher, has been named a member of the advisory board of the Institute of Juvenile Research, Chicago. Dr. Steck is former president of the Franklin County Medical Society.

GRUNDY

Physician Honored.—Dr. J. J. Coady, Minooka, was honored on his seventy-fourth birthday, July 3, when the citizens of the town held a picnic at McKinley Woods park, near Channahon. Dr. Coady graduated at the Chicago College of Physicians and Surgeons in 1907. He practiced in Mokena until 1912 when he went to Minooka

KNOX

Alexander William Burke Heads Health District.—Dr. Alexander William Burke, formerly connected with the Shelbyville District, Illinois Department of Public Health, has been named head of the Galesburg Branch, District number 4, comprising the counties of Knox, Warren, Henry, Mercer, Henderson, Hancock, McDonough and Bureau. Dr. Burke was formerly attached to the Macomb District office. After it was discontinued he went to Springfield where he was head of the district number 10 carrying a concurrent appointment of acting chief of the state division of tuberculosis control.

Unfortunately, in 1944 the Illinois Medical Journal erroneously reported that Dr. Burke died of a heart attack in Memphis. The Journal regrets that Dr. Alexander William Burke, University of Illinois, 1909, was confused with a Dr. Alexander Walter Burke, whose death occurred at that time.

LAWRENCE

Fifty Years of Practice.—On June 30, Dr. William Robert Mangum was presented with the emblem and certificate of the Fifty Year Club of the Illinois State Medical Society. Dr. Harlan English, Danville, Councilor of the Eighth Distict, made the presentation and Dr. Andy Hall, Mount Vernon, President of the Fifty Year Club, spoke. Dr. Mangum has served as county coroner and president of the Lawrence County Medical Society. He opened his first office in Elco. He then practiced for a while in Buncombe before moving to Bridgeport in July, 1912.

MACON

Ninety Years of Age.—Dr. W. T. McLean, Maroa, observed his ninetieth birthday, July 31. The physician retired in 1944 after sixty-three years of practice. He was president of the Maroa School Board of many years, president of the local grade school board and mayor of Maroa in 1895 and 1897.

MADISON

Personal.—Dr. Groves B. Smith, medical director and superintendent of Beverly Farm, was host to the Madison County Medical Society at a buffet supper, July 2.

Public Plaque Honors Physician.—On July 25 a public ceremony was held in Livingston to honor Dr. R. C. Berry who has practiced there for thirty-four years. The occasion marked the physician's sixty-second birthday. A feature of the ceremony, according to the Edwardsville Intelligence, was the dedication of a mahogany granite stone bearing the inscription: "In honor of Dr. R. C. Berry, our community doctor since 1914."

Toward the top of the stone is the silhouette of a horse and buggy. Funds for the memorial were raised by popular subscription through civic, labor and fraternal organizations sponsors of the community.

PEORIA

Annual Dinner.—Dr. David Salkin, Hopemont, W. Va., was the principal speaker at the annual dinner of the Peoria County Medical Society recently. His subject was "Treatment of Pulmonary Tuberculosis."

ROCK ISLAND

Physician Honored.—Dr. L. L. McIntyre was given a surprise party recently to honor his many years of service in New Boston. He was presented with an engraved pen and pencil set.

SANGAMON

Corporation Charter Issued.—The Sangamon County Medical Society was issued a corporation charter recently. Incorporators are Dr. Kenneth H. Schnepp, Dr. William DeHollander and Dr. Frank M. Davis, all of Springfield.

WINNEBAGO

Society News.—Dr. Leon Unger, Chicago, addressed the Winnebago County Medical Society recently on "Bronchial Asthma."

Norman Bullock Goes to California.—Dr. Norman C. Bullock, who has practiced medicine in Rockford for nineteen years and who served as city health commissioner from 1933 to 1937, has been named a member of the staff of the San Diego, California, Health Department. Dr. Bullock is a past president of the Winnebago County Medical Society.

Society News.—At the recent meeting of the American Association of Industrial Physicians and Surgeons in Boston, Dr. Harold A. Vonachen, Peoria, was elected president; Dr. Frederick W. Slobe, Chicago, secretary; and Dr. Edward C. Holmblad, Chicago, treasurer.

GENERAL

Jim Leary Opens Own Office.—Mr. James C. Leary, Public Relations Consultant of the Illinois State Medical Society, opened his own office at 185 North Wabash Avenue, Chicago (Financial 3245), July 1. Mr. Leary has for the past three years been associated with Lawrence C. Salter Associates, Chicago. He was formerly President of the National Association of Science Writers and formerly served as Science Editor of the Chicago Daily News. In his public relations work, Mr. Leary specializes entirely in educational campaigns in medical and other scientific fields.

Heart Association Names Field Director.—Appointment of Marion E. Gridley as field director of the Illinois Heart Association is announced by Dr. Harry Durkin of Peoria, president of the Association. The organization plan of the Illinois Heart Association contemplates the formation of regional units to carry on at the local level the activities of the Association and its parent organization, the American Heart Association. This program includes, according to Dr. Durkin, a broad program of research in diseases of the heart and circulation, the education of physicians and of the lay public, and community services for the benefit of the victims of heart disease. A state-wide fund-raising campaign to implement this program is planned for next February.

"Heart disease is the most challenging problem which faces physicians, labor, industry, and the general public today," Dr. Durkin points out. "There were 34,179 deaths from heart disease in Illinois last year, or 37 per cent of the deaths from all causes. But in spite of these grim statistics, the fact is that if one has heart trouble today, he is better off than he would have been at any previous time in the history of the world. This is because through the miracles of modern medicine and surgery much can be done for hearts that was never before possible. Some forms of heart disease that were incurable can now be cured or remedied so effectively that a happy, useful life is assured. Prevention, the great goal of heart research, may become a reality in the not too distant future. To speed this day is the objective of the Illinois Heart Association."

Society Created to Honor Physicians.—At a medical alumni banquet of Johns Hopkins University, honoring Drs. Helen Taussig and Alfred Blabcock, Baltimore, a National Johns Hopkins Medical Association was organized with Dr. George H. Gardner, Chicago, president, and Dr. Francis H. Redewill, San Francisco, secretary-treasurer. This new organization will take active part in social meetings of the medical alumni as well as tie in with the university's activity of developing substantial funds for new buildings.

Food and You.—The Second Annual Public Meeting on Nutrition, sponsored by the Chicago Medical Society and cooperating organizations, will be held at the John B. Murphy Memorial Amphitheater, 54 East Erie Street, Chicago on October 13 and 14, 1948.

The program has been planned to bring the public information concerning all phases of nutrition with emphasis on the health and economic aspects. An outstanding group of speakers has been secured to present the program and to answer questions from the audience during the round tables at the close of the afternoon sessions.

The public is cordially invited to attend any or all sessions. There will be no admittance fee.

October 13

10:00 A. M. to 12:30 P.M. — Colored sound movies on Conservation of Natural Resources, Soil, Agriculture, Dairy Farming, Erosion, etc.

1:30 P.M. — "The Wedding of the Sciences in Human Nutrition" — *John P. O'Neil, M.D.* Chairman Nutrition Committee, Chicago Medical Society.

2:10 P.M. — Your Meat & You, *J. Sotola,* assistant director, Livestock Bureau, Armour & Co., Chicago.

3:00 P.M. — "A National Public Health Nutrition Program" — *W. H. Sebrell, Jr., M.D.,* Director Experimental Biology and Medical Institute, U.S.Public Health Service, Bethesda, Maryland.

4:00 P.M. — "Your Dollar and Your Diet" — *Thelma Porter, Ph.D.* , Home Economics Department, University of Chicago.

4:50 P.M. — "Round Table Discussion and Questions from the Floor."

8:00 P.M. — "Maternal Nutrition and Child Health" — *Icie May Hoobler, Ph.D.,* Director, Research Laboratory Children's Fund of Michigan.

October 14

10:00 A.M. to 12:30 P.M. — Colored sound movies on Conservation of Natural Resources, Soil, Agriculture, Dairy Farming, Erosion, etc.

2:00 P.M. — "Obesity — A Prevalent Form of Malnutrition" — *William J. Darby, M.D.,* Professor of Medicine, Vanderbilt University Medical School.

3:00 P.M. — "Caloric Nutrition" — *Ancel Keys, M.D., Ph.D.* Professor of Physiological Hygiene, University of Minnesota.

4:00 P.M. — "Fat Free Certified Milk" — *Chistian E. Segard, M.D.,* Medical Director, Wisconsin Alumni Research Foundation, New York City, N.Y.

5:00 P.M. — Round Table Discussion and Questions from the Floor.

8:00 P.M. — "Public Health and Food" — *Herman N. Bundesen, M.D.* President, Chicago Board of Health.

Mississippi Valley Meeting.—The annual meeting of the Mississippi Valley Medical Society will be held at the Hotel Abraham Lincoln, Springfield, September 29-October 1, under the presidency of Dr. Willard O. Thompson, Chicago. The first day meeting will be an all day St. Louis program with the following speakers: Drs. James Barrett Brown, "Management of Compound Facial Injuries"; Grayson Carroll, "Retro-Public Prostatectomy; the Newer Anatomic Approach"; Julius Jensen, "A Discussion of the Use of Various Cardiovascular Drugs"; James L. Mudd, "Bronchogenic Carcinoma" R. O. Muether, subject not announced; Wm. A. Knight, Jr., "Chronic Recurrent Pancreatitis"; Edward H. Reinhard, "Chemotherapy of Malignant Neoplastic Disease"; Wendell G. Scott, "Advances in the Radiographic Diagnosis of Congenital Heart Disease"; and Robert Dean Woolsey, "Low Back Pain, Diagnosis and Treatment." Included among the speakers before the society will be Dr. Irving B. Brick, Washington, D.C., "Clinical Significance of Hiatus Hernia"; Anton Julius Carlson, Ph.D., Chicago, "Diet and Life Span"; Dr. L. T. Coggeshall, Chicago, "Diagnosis and Treatment of Parastic diseases," "Clinico-Pathologic Conference"; Dr. Arthur R. Colwell, Evanston, "Comparison of Intermediate Insulins", "Clinico-Pathologic Conference"; Dr. Percy E. Hopkins, Chicago Round Table Luncheon Moderator; Dr. Mayo H. Soley, Iowa City, Iowa,"Radio-active Iodine, Its use in Thyroid Disease"; Dr. Waltman Walters, Rochester, Minn., "Surgical Lesions of the Pancreas", "Cancer of the Stomach" and "Clinical-Pathologic Conference"; Dr. William B. Wartman, Chicago, "Clinico-Pathologic Conference"; Dr. A. W. Adson, Rochester, Minn., "Surgical Lesions of Spinal Cord; Diagnosis and Treatment"; Dr. Paul C. Bucy, Chicago, "Simulation of Multiple Sclerosis by Herniated Cervical Intervertebral Discs"; Dr. Fremont A. Chandler, Chicago, "Fractures of Upper end of Femur"; Dr. Jerome R. Head, Chicago, "Surgical Treatment of Stricture of the Esophagus"; Dr. Norris J. Heckel, Chicago, "Cystitis: The Causes and Treatment"; Dr. Paul S. Rhoads, Chicago, "Clinical Experience With a New Sulfonamide", "Clinico-Pathologic Conference"; Dr. T. H. Seldon, Rochester, Minn., "Recognition and Treatment of Reactions to Transfusions Administered During Surgery"; Dr. John B. Youmans, Chicago, "Nutritional Anemias" and Dr. Nathaniel G. Alcock, Iowa City, Iowa.

The third day meeting will also include scientific and technical exhibits. Dr. Harold Swanberg is secretary of the society.

Population in State Public Welfare Institutions.—The population present in all institutions of the Department of Public Welfare June 30, 1948 was 46,420 an increase of 1,544 over June 30, 1947. On the books of all institutions including those present, in family care, paroled, escaped and all other absences were 53,259.

The greatest increase over June of last year was in the nine hospitals for mentally ill, the population of which rose 1,386. There were 1,181 admissions as compared to 987 in June 1947. For the fiscal year July 1, 1947 through June 30, 1948 there were 12,840 as compared to 10,678 for the fiscal year July 1, 1946 through June 30, 1947. In these hospitals were 34,060 patients and a total of 37,242 on the books.

The institutions for mental defectives — Dixon State Hospital and Lincoln State School and Colony showed an increase of 227 over the previous year. The population present was 9,188 with 10,602 on the books.

There were 379 in Security Hospital, an increase of 5 over the same month last year.

At Neuropsychiatric Institute, where most admissions are for tempory detention for special treatment, 66 patients were present June 30, 1948.

Clinics for trachoma control and prevention of blindness, held in southern Illinois, provide treatment not only for trachoma but glaucoma and other eye diseases. During June, 251 received treatment for trachoma, 53 for glaucoma and 505 for other eye ailments. Sixteen were hospitalized for operations.

The Chicago Community Clinic reported 683 interviews for the month. Six hundred and fifty-five were formerly patients in state hospitals, 278 at Elgin and 248 at Manteno.

The Eye and Ear Infirmary dispensary listed 18,862 treatments in June, and 459 persons were admitted to the hospital.

The Welfare Institutions reported 1,361 new cases and 5,809 old dental cases for June.

The Boys' Training School, Girls' Training School and Women's Reformatory reported 909 juvenile delinquents, felons and misdemeanants present June 30, a decrease of 224 as compared to a year ago. There were 683 juvenile delinquents present June 30, a decrease of 224 as compared to 881 one year ago.

On June 30, the children from the School for the Deaf and Blind were on summer vacation. There were 292 children present at the Soldiers' and Sailors' Children's School. The Children's Hospital-School for physically handicapped children had an enrollment of 75. Sixty-three were present, an increase of 34 over a year ago.

The Industrial Home for the Blind, Soldiers' Widows' Home and Soldiers' and Sailors' Home reported 1,351 present, an increase of 149 over a year ago.

The Veterans' Rehabilitation Center in Chicago, and Veterans' Clinics in Urbana and Aurora received

78 new cases during the month. There were 1,112 visits to the Clinic in Chicago, 176 in Urbana and 50 in Aurora. Since the opening of the Center, 4,553 veterans have received treatment in Chicago, 120 in Urbana and 18 in Aurora.

The Division of Veterans' Service reported 2,688 veterans present in all State Welfare Institutions June 30.

The Institute for Juvenile Research interviewed 235 new cases, 91 from Cook County and 39 from Cook County Juvenile Court in June. A total of 530 children and 675 adults, old and new cases, were examined and received treatment.

For the first time reports have been compiled from data furnished by the Division of Supervision of Delinquents. During the month of June, 70 placements were made. These were placed in boarding foster homes, boarding homes, foster homes and welfare homes. For the fiscal year July 1, 1947, through June 30, 1948, 710 placements were made.

In addition 1,263 patients were interviewed in out-patient clinics, and there were 2,251 visits to these clinics.

HEALTH DEPARTMENT ACTIVITIES

First Statewide Fly Control Program.—Nearly all Illinois counties are participating in the first statewide fly-control program which is being sponsored by the University of Illinois extension service, the Illinois Agricultural Association, the Illinois natural history survey, and the state department of public health, according to Dr. Roland R. Cross, state director of public health. This widespread program actually commenced last year when a mobile DDT spraying unit toured most of Illinois, demonstrating, in cities and on farms, the latest methods of fly-control. In addition, this unit attended many county fairs and the Illinois state fair. Through the spraying of the fairgrounds, fly prevalence in these areas was decreased to nearly zero.

Again this year, this unit is giving demonstrations in communities throughout the state. This program has done much to enlist the aid of local groups in the all out fight for a fly-free Illinois. Pointing out that flies are known carriers of more than a score of infectious diseases, Dr. Cross urges the residents of Illinois to continue to cooperate in the program to rid the state of flies.

News of Personnel.—Dr Richard F. Boyd has resigned his post as chief of the Division of Local Health Administration to accept a position with the Health and Welfare Fund of the United Mine Workers of America at Washington, D.C. — Dr. Charles F. Sutton has been appointed to the position of chief of the Division of Local Health Administration to succeed Dr. Boyd. Dr. Sutton was serving as assistant chief. — Dr. D. F. Rawlings, health officer for District No. 4, Galesburg, has accepted the position of assistant chief of the Division of Local Health Administration under Dr. Sutton. On June 15, 1948, State District Health Office No. 14, at Shelbyville, was closed. Dr. A. W. Burke, district health officer, moved his headquarters to District No. 4 at Galesburg on that date.

Christian, Clark, Cumberland and Fayette Counties, which formerly comprised District No. 14, have been assigned to other districts as follows: Christian, Clark, and Cumberland Counties to District No. 11. Fayette County to District No. 16.

The health officer of District No. 11 is Dr. W. M. Talbert whose office is at 402 Macon County Building, Decatur. His telephone numbers are — office: 9512, home: 6712.

The District No. 16 health officer is Dr. Norman J. Rose, whose office is in the Highland National Bank Building, Highland. Dr. Rose's telephone numbers are — office: 375, home: 43W.

The State's Health in 1947.—The health record of Illinois for 1947 was comprehensively discussed in Health Statistics Bulletin, June 23. The year recorded the highest birth rate, 23.4 per thousand, two per thousand above the previous high mark established in 1946. About 94 percent of all the babies were born in hospitals. Only three out of every thousand babies were attended to at birth by a midwife or other non-medical practioner.

Although there were almost four thousand more deaths in 1947 than in 1946, the general death rate remained practically unchanged in rising from 11.0 to 11.2 per thousand inhabitants. The death rate remained so steady because the state's population at midyear 1947 was estimated to be 192 thousand greater than at midyear 1946. While a considerable part of this apparent increase represents the return of people from the armed services, the greatest part is due to the great rate at which births out-strip deaths. During the year, births exceeded deaths by almost 100,000, another new record, the reports states. During the year, there were only ten deaths from maternal causes for every ten thousand new babies. Influenza and pneumonia mortality increased with a combined rate for the two deseases of 39.9 deaths per hundred thousand inhabitants as compared to 37.8 in 1946. Tuberculosis mortality reached another new low with 33.7 deaths in 1947 as compared with 81.5 in 1921. Pulmonary tuberculosis was responsible for 92 percent of the 2,770 deaths from all forms of tuberculosis recorded in 1947. There were twice as many deaths from tuberculosis in males as in females.

Communicable diseases declined. Undulant fever mortality recorded five deaths in 1947 as compared to one death in 1946.

Heart disease and cancer deaths increased with heart disease rising to an all time high with 416 deaths per hundred thousand population in 1947.

Motor vehicle accidents declined and deaths by suicide remained essentially the same as in 1946 while the rate for homicides decreased slightly. Unusual deaths included in the report were two from leprosy that occurred in the Chicago area.

bringing the total for the state to six since 1921, the first year for which accurate vital records for the state are available. One death from beriberi was reported, the first since 1943. The report indicates there is reason to believe that the figure would have been higher if the beriberi heart were better recognized.

DEATHS

Alexander Walter Burke, Chicago. Died June 4, 1944 in Memphis, Tennessee. Graduate of Loyola School of Medicine, 1916.

Cornelia B. De Bey, Chicago, who graduated at Hahnemann Medical College and Hospital in 1895, died in Grand Rapids, Michigan, April 3, aged 82, of cerebral hemorrhage.

Henry Bardwell Donaldson, Chicago Heights. who graduated at Northwestern University Medical School in 1909, died in St. James Hospital, March 22, aged 68.

Frederick B. Fox, Freeburg, who graduated at St. Louis University School of Medicine in 1906, died July 21, aged 76.

Edgar Agassiz Green, Ridgeway, who graduated at Barnes Medical College, St. Louis, in 1898, died after a prolonged illness, July 26, aged 74.

Edward Marcellus Holmes, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1903, died in Oak Park, Ill., March 24, aged 71.

Orton Charles Hyslop, Spring Valley, who graduated at Northwestern University Medical School in 1916, died at Peoples Hospital, Peru, Ill., July 22, aged 56. Had practiced medicine in Spring Valley since 1925.

Stanley Frederick Johnson, Chicago, who graduated at Northwestern University Medical School in 1925, died in Passavant Memorial Hospital, April 25, aged 50, of cerebral accident.

Thomas Alfred Jones, Zeigler, who graduated at Marion-Sims College of Medicine, St. Louis, in 1887, died July 3, aged 79. He had practiced medicine in Zeigler for 25 years.

Warren Walker Keene, Lewistown, formerly of Yates City, who graduated at National Medical University, Chicago, in 1909 and College of Medicine and Surgery, Chicago, in 1911, died in St. Mary's Hospital, Galesburg, July, aged 61. He had been an invalid for over a year.

Harry Corwin Moss, Carbondale, who graduated at Missouri Medical College, St. Louis, in 1898, died in Holden Hospital with which he was affiliated, March 23, aged 75, of congestive heart failure.

Frank J. Novak, Jr., Chicago, who graduated at the University of Illinois College of Medicine in 1914, died July 27, aged 60, of coronary sclerosis. He was a member of the senior attending staff of Henrotin Hospital and a specialist certified by the American Board of Otolaryngology.

Thomas Philip O'Connor, Chicago, who graduated at the John A. Creighton Medical College, Omaha, in 1914, died in Wesley Memorial Hospital March 25, aged 56, of peptic ulcer. He was assistant professor of otolaryngology at Northwestern University Medical School; a specialist certified by the American Board of Otolaryngology; on the courtesy staff of the Passavant Memorial Hospital; chairman of the department of Otolaryngology, Wesley Memorial Hospital.

Frank Joseph Ronayne, River Forest, who graduated at Yale University School of Medicine in 1904, died in St. Petersburg, Fla., March 24, aged 71, of pneumonia. He was a member of the Radiological Society of North America, Inc.

Edwin Louis Rypins, Bloomington, who graduated at University of Nebraska College of Medicine in 1927, died July 4, as a result of injuries received in an automobile accident. He was 45 years old.

Fred Seymour Saruk, Chicago, who graduated at Chicago Medical School in 1946, died in the Winfield Hospital March 14, aged 40, of pulmonary tuberculosis.

Hiram Jason Smith, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died in Illinois Central Hospital, February 16, aged 65, of uremia. He was clinical associate professor of ophthalmology at his alma mater; specialist certified by the American Board of Ophthalmology; chief oculist for the Illinois Central Railroad.

Charles Frederick Stotz, Chicago, who graduated at the University of Illinois College of Medicine in 1898, died July 18, aged 76, of carcinoma. He was connected with Walther Memorial Hospital since its founding, serving as chief of staff, president, and recently elected president emeritus of the staff. He had recently been made a member of the "Fifty Year Club" of the Illinois State Medical Society, and was a member of American College of Surgeons.

Clifford John Stricker, Marseilles, who graduated at Northwestern University Medical School in 1928, died, July 23, in a Los Angeles Hospital, from a throat ailment. He was 47 years of age. He was a past president of the LaSalle County Tuberculosis Sanitarium and at the time of his death, president of LaSalle County Medical Society.

George Ulysses Washborn, Peoria, who graduated at the Hahnemann Medical College and Hospital, Chicago, 1902, died March 14, aged 68, of coronary thrombosis and carcinoma of the prostrate.

"FOR THE COMMON GOOD"

The Mercer County Medical Society called a special meeting August 4, to hear Fred V. Hein, Ph.D., consultant in health and fitness, Bureau of Health Education, American Medical Association, Chicago, discuss "Physicians and Schools." This lecture was arranged through the cooperative policy of the Bureau of Health Education, AMA, and the Educational Committee of the Illinois State Medical Society whereby any AMA staff member who appears in Illinois towns clears the request with the Educational Committee. The latter then notifies the County Medical Society concerned. In some instances the County Medical Society arranges meetings of Civic groups to hear the AMA staff member.

Bill Dozier, new Public Relations director for the Alabama State Medical Association, visited the Chicago Office of the Illinois State Medical Society recently where he consulted with Dr. James H. Hutton and Mr. John Neal, Chairman and Executive Secretary, Committee on Medical Service and Public Relations, Mr. James C. Leary, Public Relations Counsel, and Ann Fox, Secretary of the Educational Committee.

Mrs. Walter Shriner, Springfield, President, Woman's Auxiliary, Sangamon County Medical Society, visited the Chicago Office recently, conferring on the Auxiliary's plans to staff the Exhibit of the Illinois State Medical Society during the State Fair, August 13-22.

Richard B. Capps, Chicago, and his paper on "Infectious Hepatitis", presented before the 1948 Annual Meeting of the Illinois State Medical Society, made the August issue of Science Illustrated.

Paul Jones, Director of Public Information, National Safety Council, in a letter June 30 said thanks to the Educational Committee for using their safety slogans in its *Health Talk*. Mr. Jones said "we are grateful and flattered."

Mr. A. H. Lancaster, Superintendent, Dixon Public Schools, Dixon, in July asked for 250 copies of the *Health Talk* entitled "What is the Health Future of Your Child" for use in the schools.

The West Virginia State Medical Journal in August editorialized the *Health Talk* on "Vacations" and reprinted it in full.

Mrs. Charles W. Sewell, Administrative Director, Associated Women of the American Farm Bureau Federation, requested 100 copies of the *Health Talk* on Undulant Fever, fifty of which were to be given to the State Leaders in the Regional Training Schools. The remainder was to be distributed through their Livestock Department.

Mr. Joseph F. Donovan, Executive Secretary, Santa Clara (California) County Medical Society, on July 16 requested copies of material released through various Committees of the Society, and complimented "The Doctor and His Medical Society," the pamphlet which was his source of information.

A Bouquet to Marion County for Something New in Postgraduate Conference Publicity! — On July 15 Dr. Max Hirschfelder, Secretary, Marion County Medical Society, sent out a letter to the members in the Seventh District of the Illinois State Medical Society announcing the Postgraduate Conference for the District. In August a second letter was mailed. This sincere effort to stimulate interest and good attendance at the Centralia Conference, September 16, deserves special commendation. It was good promotion and excellent publicity. The first letter follows:

To the physicians of the
Seventh District of the
Illinois State Medical Society

Dear Doctor:

Take a pencil and circle Thursday, September 16, right now!

This is your splendid opportunity given by the Illinois Medical Society to learn some new things in a post-graduate medical conference held in Centralia, September 16, in the afternoon and evening.

You know that these post-graduate conferences, which are under the auspices of the Post-graduate Educational Committee of the Illinois State Medical Society, are especially designed to keep the general practitioner of the smaller towns up to date with all the developments of modern medicine. The Marion County Medical Society, who is sponsoring the program for this year for Seventh District, is making every effort to make this a splendid meeting, from a social, as well as a professional standpoint. There will be a complimentary luncheon. The dinner in the evening will be $2.50.

You will be kept informed about the exact program featuring Chicago and St. Louis speakers.

Right now, make a circle around September 16, and keep it open!

You will enjoy the meeting.

Very truly yours,
Max Hirschfelder, M.D., Secretary
Marion County Medical Society

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society; Charles P. Blair, Monmouth, Chairman:

Charles N. Pease, Chicago, South Edgebrook Woman's Club, Chicago, November 22, on Spastic Paralysis.

W. W. Bolton, Associate Director, Bureau of Health Education, American Medical Association, William Howard Taft P.T.A., Chicago, January 17, on Good Health Habits for Teen Agers.

Howard M. Sheaff, Oak Park, Berwyn Woman's Civic Club, January 18, on Your Heart is Worth Protecting.

George A. Hellmuth, Chicago, Young Mothers' Club of Bryn Mawr, Chicago, January 24, on Your Child's Heart.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Socity; Robert S. Berghoff, Chicago, Chairman:

B. C. Kilbourne, Chicago, Fulton County Medical Society in Canton, September 17, on Fractures of the Hand.

Louis E. Limarzi, Chicago, Effingham County Medical Society, in Effingham, September 23, on Hematologic Disorders of Interest to the General Practitioner.

Carlo Scuderi, Chicago, DeKalb County Medical Society, in DeKalb, September 28, on Backache from an Orthopedic Standpoint and Its Treatment, illustrated with slides.

Harold A. Sofield, Chicago, Kankakee County Medical Society, Kankakee, October 8, on Treatment of Fractures of the Femur.

John Vonachen, Peoria, McDonough County Medical Society in Macomb, October 22, on Pediatric Problems with Special Reference to Infant Feeding, illustrated with slides.

Louis Limarzi, Chicago, DeKalb County Medical Society, October 26, on Diagnosis and Treatment of Common Blood Disorders.

Postgraduate Conferences Arranged Through the Postgraduate Education Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman:

District	Status
First	Not Determined
Second	Not Determined
Fourth	Not Determined
Fifth	Pekin, October 1948
	Springfield, March 3, 1948
Sixth	Carlinville, cancelled
	Quincy, sometimes in Spring
Seventh	Centralia, September 16
Eighth	Not Determined
Ninth	Harrisburg, September 22
Tenth	Duquoin, latter part of March or first of April
Eleventh	Not Determined

TB, 1900-1946

The greater average length of life means a greater number of years lived. It might be interesting to calculate to what savings the increase is principally due. The disease tuberculosis furnishes one of the best examples. In 1900 is was easily the leading cause of death. The mortality rate was 195 per 100,000 population. Forty-six years later, in 1946, the total number of deaths from the disease during the year was about 50,000, and the rate had dropped to 36. Had the 1900 rate still held, the number of deaths would have been 273,000. The saving of life in that year was therefore 223,000. For the total 46-year period it has been calculated that approximately 5,000,000 lives were saved.

Allowing for increasing population, decreasing death rate, and average ages at death from tuberculosis and all causes, it is clear that between 1900 and 1946 many millions of years were lived that would not have been lived had the mortality rate for tuberculosis in 1900 been maintained.

The saving of life is not the only saving to consider. For every person who dies of tuberculosis in any one year, about four are alive and seriously ill with it. Using the same figures as before, and subtracting the calculated cases from the total that would have existed in 1946 had the 1900 rate prevailed, we find a saving in that year alone of 892,000 serious cases. Quite comparable calculations could be made for other diseases. —Esmond R. Long in *Science*.

Historians (Continued)

Union County: — Dr. E. Vincient Hale, 211½ S. Main St., Anna, Illinois
Vermilion County: — Dr. A. R. Brandenberger, 106 N. Vermilion, Danville, Illinois
Wabash County:
Warren County: — Dr. Charles P. Blair, 102 S. 1st Street, Monmouth, Illinois
Washington County: — Dr. George Klostermann, Hoyleton, Ill.
Wayne County: — Dr. Kenneth O. Hubble, Fairfield, Ill.
White County: — Dr. J. Z. Stanley, Carmi, Illinois
Whiteside County: — Dr. W. H. Perry, Sterling, Illinois
Will-Grundy County: — Dr. Marian K. Bowles, 111 S. Richards St., Joliet, Illinois
Williamson County: — Dr. Frank Murrah, Herrin, Illinois
Winnebago County: — Dr. J. Howard Maloney, Gas & Electric Bldg., Rockford
Woodford County: — Dr. Robert E. Gordon, ElPaso, Illinois

— WOMAN'S AUXILIARY —

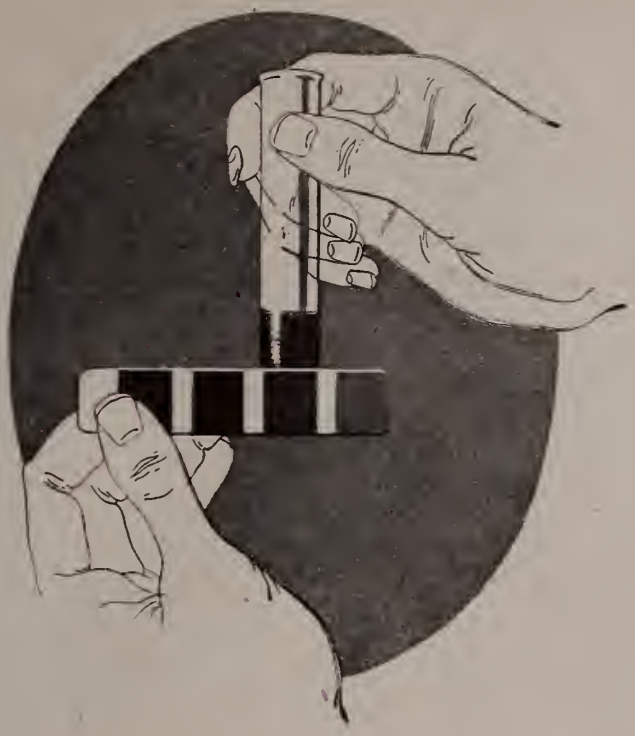
Adams County: — Mrs. Walter Stevenson, 230 S. 16th St., Quincy
Bureau County: — Mrs. Charles J. Green, 128 W. Cleveland St., Spring Valley
Cook County: — Mrs. H. L. Schmitz, 10257 S. Leavitt St., Chicago
Henry County: — Mrs. C. Paul White, 733 Henry Street, Kewanee
Kane County: — Mrs. C. O. Heimdal, 68 LeGrand Blvd., Aurora
Knox County: — Mrs. Irving Schipper, 1216 N. Cherry St., Galesburg
Livingston County: — Mrs. A. J. McGee, 205 N. Clinton St., Dwight
Logan County: — Mrs. A. M. Drummy, 110 Peoria St., Lincoln
Madison County: — Mrs. L. L. Grzesk, Granite City
Marion-Clinton County: — Mrs. C. H. Black, 100 West Main St., Salem
Peoria County: — Mrs. Walter King, 103 High Street, Peoria
Rock Island County: — Mrs. G. W. Koivun, 1702 30th Street, Moline
Sangamon County: — Mrs. Walter Shriner, 913 Williams Blvd., Springfield
St. Clair County: — Mrs. Henry H. Hurd, 72 Country Club Place, Belleville
Tazewell County: — Mrs. Harold Feldman, 705 S. 5th Street, Pekin
Vermilion County: — Mrs. D. L. Dickerson, 2315 N. Vermilion St., Danville
Warren County: — Mrs. Russell M. Jensen, 303 E. Broadway, Monmouth
Will-Grundy County: — Mrs. George Carlin, 506 Buell Ave., Joliet

MEMBERS AT LARGE

Lawrence County: — Mrs. Frank Arnold, Lawrenceville
Douglas County: — Mrs. O. C. Blaine, Tuscola
Whiteside County: — Mrs. Frank Brodrick, Sterling
Gallatin County: — Mrs. E. W. Burroughs, Shawneetown (now of Houston, Texas)
Perry County: — Mrs. J. H. Edwards, Pinckneyville
Ford County: — Mrs. S. B. Furby, 632 S. Washington St., Paxton
Florence Ave., Oglesby
LaSalle County: — Mrs. T. S. Huggard, 347 W. Florence Ave., Oglesby
Lawrence County: — Mrs. R. Kirkwood, 1608 Power St., Lawrenceville
Clark County: — Mrs. David Illyes, 404 N. Maple Ave., Marshall
Coles County: — Mrs. J. J. Link, Mattoon
Gallatin County: — Mrs. W. F. Stanelle, Shawneetown
Champaign County: — Mrs. W. E. Schowengerdt, 301 E. University Ave., Champaign
Crawford County: — Mrs. B. C. Teasley, Robinson
Champaign County: — Mrs. Willard L. Veirs, 502 W. Pennsylvania Ave., Urbana
Winnebago County: — Mrs. E. H. Weld, Route 2, North Second Road, Rockford

IT'S YOUR INVESTMENT

"Let me appeal to you as one would to a stockholder in a corporation to be present at all county society meetings. You are investing in this society in the form of the dues. It is your duty as an investor to be present at meetings to see that your ideas are carried out."—W. Bernard Yegge, M.D., Presidential Address, Medical Society of the City and County of Denver.



TO RESTORE THE BALANCE

Few therapeutic procedures can be used with such precision and with such assurance of benefit as the modern treatment of diabetes mellitus. Not only can the degree of defect in the metabolic capacity of the diabetic be readily determined, but it is easy to increase the patient's capacity if desirable. If his own supply of insulin is insufficient to support the normal metabolic load, it can be made adequate by supplementing with Insulin administered hypodermically.

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For sustained effect—

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Intermediate effects may be obtained by suitable admixtures of Insulin and Protamine Zinc Insulin.

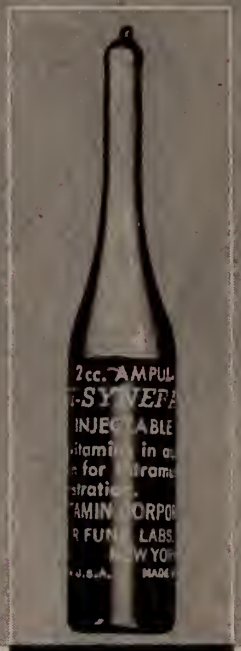
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Pyridoxine HCl (B_6)— 3 mg.
Niacinamide—20 mg.
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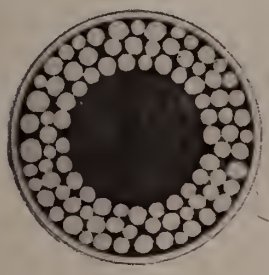


Detailed literature and sample

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The coating of Barlow-Maney Tablets Aminophylline Enteric Coated is described in New and Nonofficial Remedies, 1946.



LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

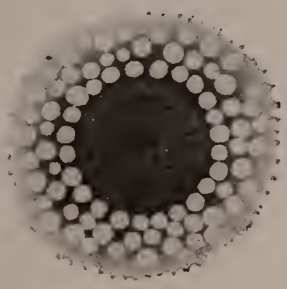


Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.



Fig. 3 — Complete disintegration.

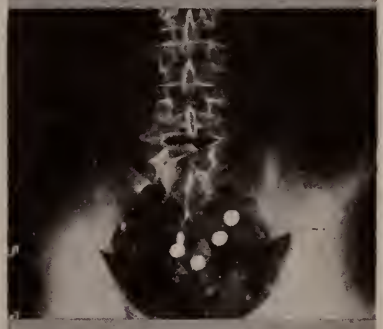
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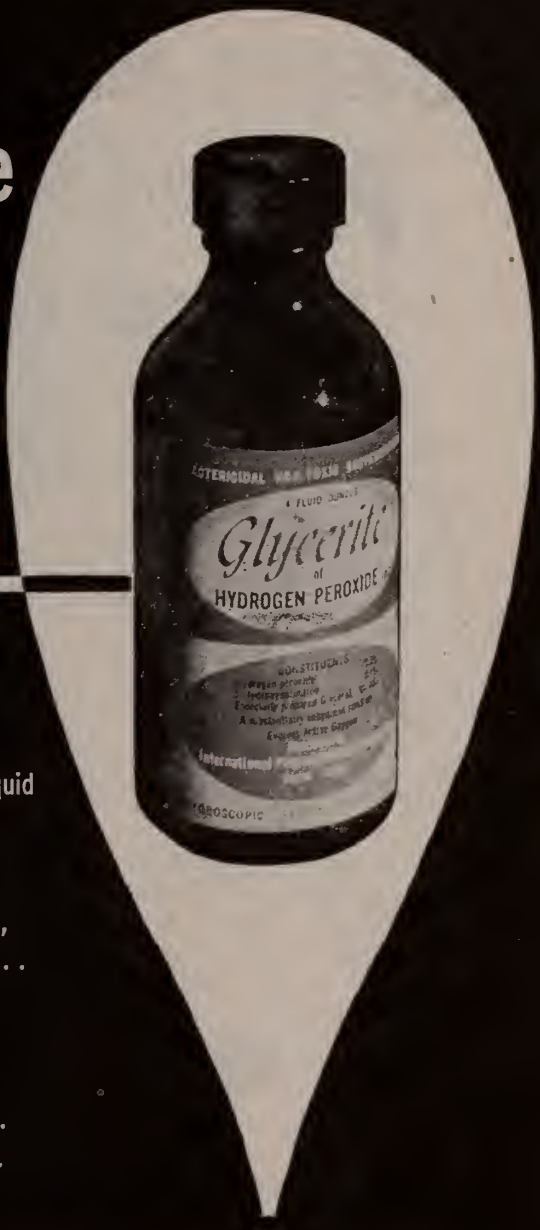
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Bibliography:

New Eng. J. Med.	234:468, 1946.
J. Invest. Derm.	8:11, 1947.
Annals of Allergy	4:33, 1946.
Science	105:312, 1947.
J. Bacteriology	Vol. 53, June, 1947.

Literature on request.

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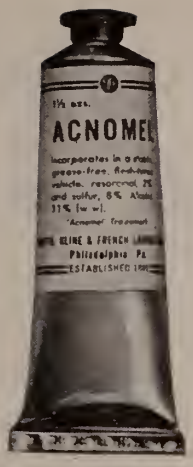
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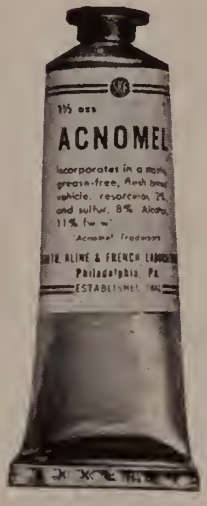
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PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER



PHYSICAL MEDICINE IN THE TREATMENT OF FRACTURES

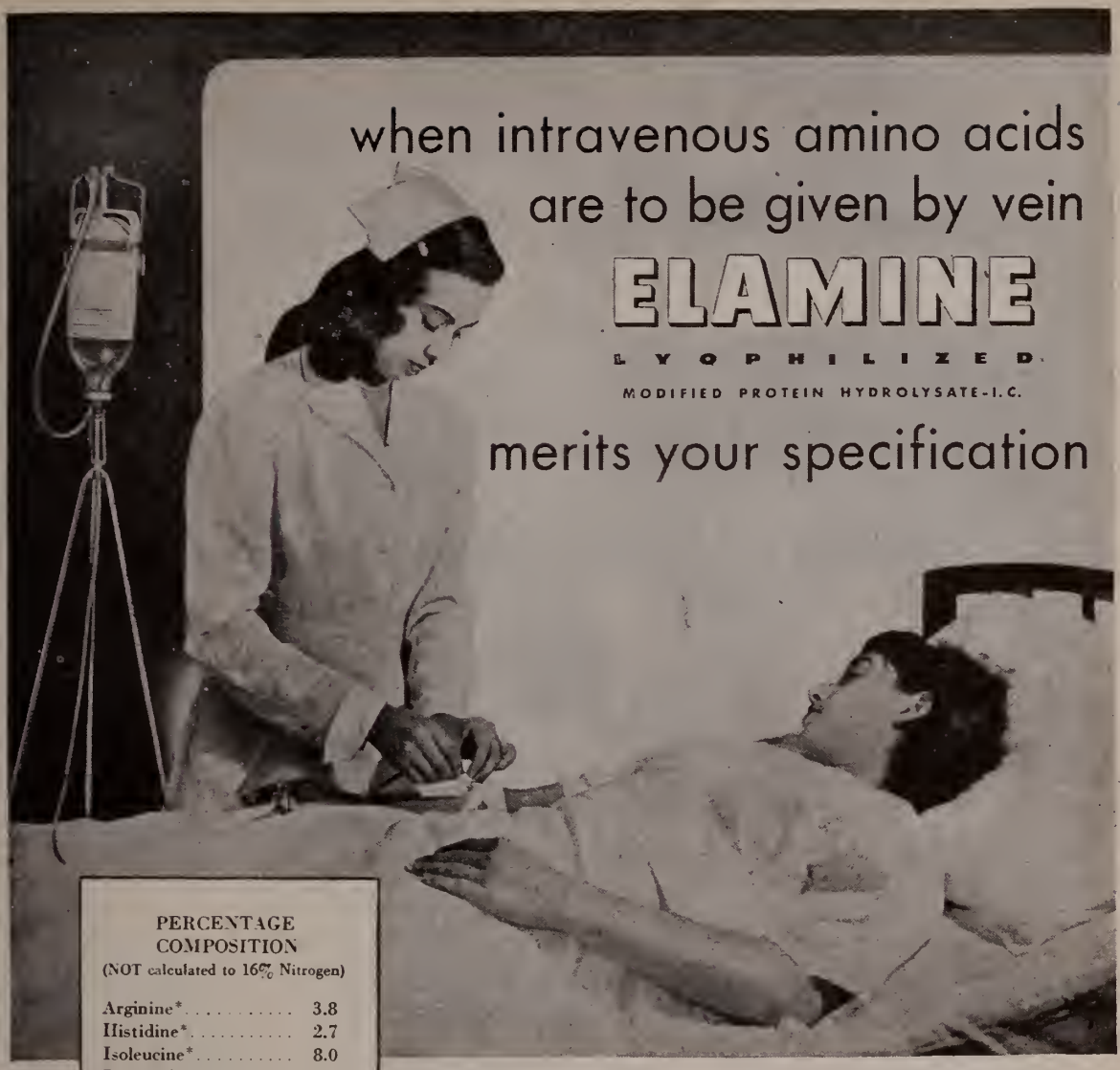
Miland E. Knapp, M.D., Minneapolis, Minn. In JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 137:136 May 8, 1948.

Treatment for these conditions should be started immediately after the fracture is reduced and immobilized. At first the treatment should be directed mainly toward the removal of hemorrhage and edema. This may be accomplished most efficiently by active exercise. Normal venous return flow circulation from the extremities is accomplished through muscle contraction. By careful choice of the immobilizing apparatus, active motion of some portion of the extremity is usually feasible throughout the period of immobilization. Close fitting, nonpadded plaster casts, trimmed so that motion is possible in all joints except those required to maintain the immobilization, are usually satisfactory in those patients that are ambulatory. Skeletal traction and internal fixation in the more serious cases allow adequate immobilization of the fracture line with minimum immobilization of surrounding joints. Elevation of the affected part is a useful adjunct in removal of swelling. However, it must be remembered that for elevation to be effective, the extremity must be so arranged that there is a continuous downhill slop from the fingers or toes to the body. This means in the upper extremity that the hand must be above the elbow and the elbow above the shoulder. Obviously this is not a practical position unless the patient is in bed. The use of a sling in a Colles fracture, for instance, does not prevent swelling because an uphill grade is still present between the elbow and the shoulder. If adequate activity or elevation or both can be accomplished immediately after the fracture has been reduced the problem of removal of swelling has usually been solved and routine care in the department of physical medicine will be reduced to a minimum.

The physiologic effects of massage vary with the type and dosage employed. However, as used in the early treatment of fractures (superficial stroking) the effects are: (1) sedation and relief of pain and muscle spasm; (2) increase of circulation, this time the greatest effect is on the venous side of the circle so that return flow is facilitated both reflexly and mechanically; (3) subsequent decrease of swelling because of the increased venous circulation.

Wherever voluntary active motion may be impractical or impossible, as in nerve injuries, the use of electrical stimulation will help prevent muscle atrophy and circulatory dysfunction. The faradic current may be used if the nerve

(Continued on page 46)



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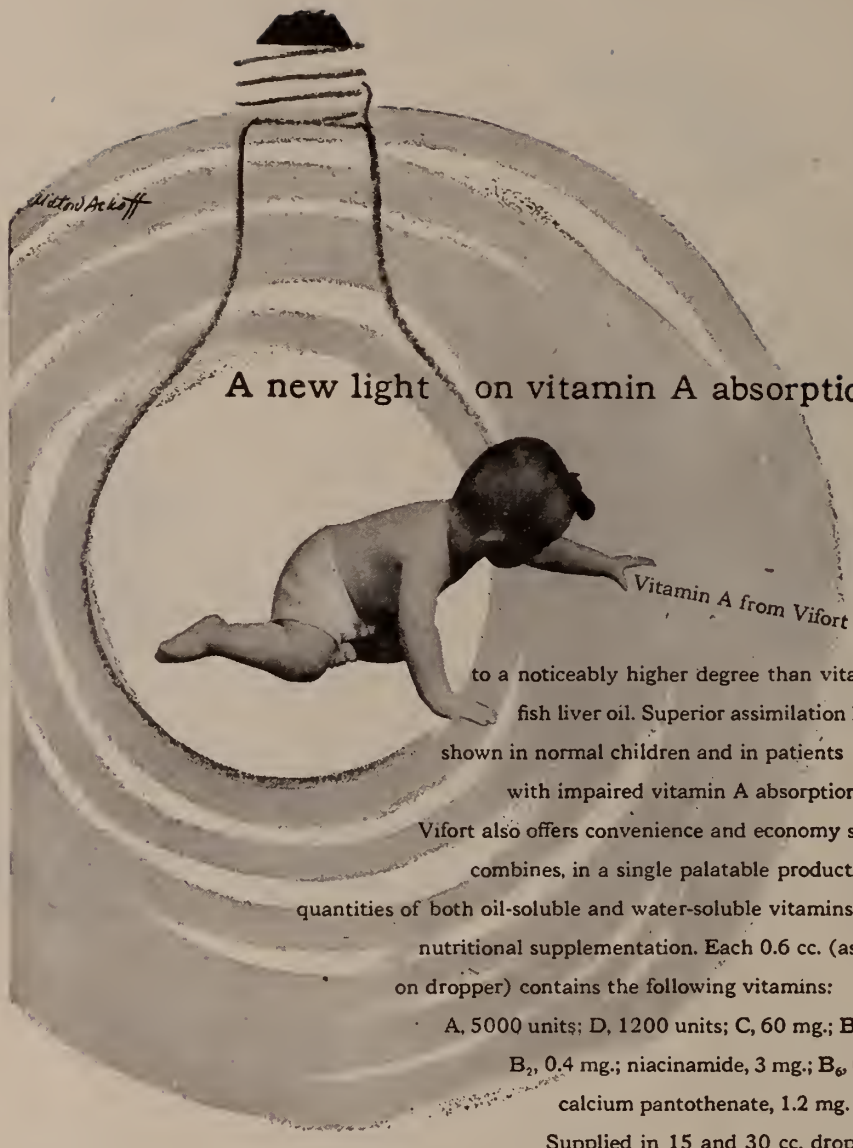
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is intact, but the interrupted galvanic or sinusoidal current must be used if the nerve is severed and the nerve endings are degenerated.

Active motion of all joints not necessarily immobilized must be insisted on between treatments throughout the course of fixation if muscle atrophy and fibrosis are to be prevented and limitation of motion is to be kept at a minimum.

While recreational therapy is useful when the patient is in bed and has a limited usefulness during early convalescence, vocational methods appear to be much more vauable when the patient is in the later convalescent stages. The tendency at the present time is to emphasize the vocational methods and to deemphasize recreational occupational therapy.

SERRATUS MAGNUS PARALYSIS

K. G. Hansson, M.D., New York. In ARCHIVES OF PHYSICAL MEDICINE, XXIX:3:156, March 1948.

The follow-up of 28 patients with paralysis of the serratus magnus muscle and the observation of 3 additional patients still under the treatment justifies the following conclusions:

1. In most cases the condition is idiopathic; there usually is a history of exposure with a possible avitaminosis. Trauma, including postoperative and postpartum, is responsible for a considerable number of cases. Serratus magnus paralysis may also follow tetanus antitoxin injections and poliomyelitis.

2. The deformity produced by serratus magnus paralysis is protrusion of the medial end of the scapula and a rotation of the scapula upward end laterally. Immobilization should therethe scapula to the thoracic wall and also defore be accomplished by a support that presses rotates the scapula. Additional treatment is electrical stimulation and specific exercises.

3. With the use of this kind of immobilization and treatment, 28 patients were relieved of their symptoms.

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X-RAYS FOUND EFFECTIVE IN DISEASE OF LYMPH GLANDS

X-rays have been found very helpful in the treatment of a comparatively newly described disease of the lymph glands, according to Dr. Sidney Rubenfeld, of the Department of Radiation Therapy, Bellevue Hospital, New York.

Writing in the July 3 issue of The Journal of the American Medical Association, Dr. Rubenfeld reports a fairly high percentage of treated patients who have survived five years or more.

The lymph gland disease which The Journal article describes is known medically as giant follicular lymphadenopathy or Brill-Symmers disease, named after Nathan E. Brill, a New York physician who died in 1925, and Douglas Symmers, a New York pathologist.

The disease is characterized by enlargement of the lymph nodes in various parts of the body and enlargement of the spleen, these enlargements being due to the abnormal multiplication of normal cells within the lymph nodes. These nodes are tiny organs scattered in many parts of the body, especially in the neck, armpits, around the roots of the lungs, around the intestines and in the groins.

This disease, the article says, has been "widely recognized by pathologists but is only beginning to attract the attention of clinicians, among whom it is almost always mistaken for Hodgkin's disease. Both are primarily diseases of the lymphoid system."

Dr. Rubenfeld's paper was based on a study of 19 patients with giant follicular lymphadenopathy or with polymorphous cell sarcoma, which is a highly malignant tumor containing cells of several varieties. The oldest patient was 59, the youngest 12. There were five females and 14 males. Enlarged lymph nodes constituted the outstanding clinical feature.

X-rays were used in the treatment of all 19 patients.

"In addition to the difference in the degree of response there were variations in the rapidity of the recession," the doctor pointed out.

Sixty-six per cent of patients with giant follicular lymphadenopathy and 60 per cent of those with polymorphous cell sarcoma are apparently well five or more years after the institution of treatment, the article says.

Heretofore, five year survival rates for diseases of this kind were quoted in the medical literature at only 47 to 50 per cent.

The unsolved problems of public health and preventive medicine lie in the field of health protection and health promotion of the adult, particularly the young adult, who is the most productive member of society. It is also quite clear that problems of adult hygiene cannot be solved by the methods of mass approach. Medicine in the Changing Order, Rep. New Fund, 1947.



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HOUSE DUST MAY CAUSE INFANTILE ECZEMA

The possibility that house dust is an important cause of atopic dermatitis; or infantile eczema, is advanced by Jerome Glaser, M.D., of Rochester, N. Y., writing in a recent issue of The Journal of the American Medical Association.

Infantile eczema is an allergy disease which, it is believed, is caused by direct contact of the skin with certain allergens, as well as by allergens which have been inhaled and which reach the skin through the blood stream. An allergen is any substance which is capable of inducing allergy or specific susceptibility.

Among the characteristics of atopic dermatitis are watery sores, scales and crusts, and itching or burning sensations. The affliction is commoner in infants and children because their tender skins are more easily penetrated by allergens than those of adults.

According to Dr. Glaser, "the characteristic distribution of atopic dermatitis, with lesions worse on the face, the area of the arms below the elbows and the legs below the knees, suggests a possible contact origin." In view of this, he says, "it is tempting to consider that such lesions might be caused by a ubiquitous and powerful allergen, house dust, which could act either by contact or inhalation."

As further evidence of the importance of house dust in causing infantile eczema, Dr. Glaser points out that "the often remarkably beneficial results of hospitalization are commonly attributed to avoidance of house dust as well as of other environmental allergens," adding that good results in the alleviation of the condition have also been attained by treating patients with injections of house dust extract.

According to the article, there is no completely satisfactory treatment of infantile eczema and therefore "the problem is to do the best one can with a disease which is usually self limited, with a tendency to spontaneous remissions and eventual recovery regardless of therapy."

Prophylactic, or preventive measures, such as avoidance of dust or irritating wool clothing, are considered important in the orthodox treatment of the disease. Special baths, prepared by adding a cup or two of cornstarch to a tub of tepid water, are also recommended for early stages of the disease.

The local application of paste of resorcinol, made up of one part zinc oxide, one part corn or arrowroot starch, and two parts white petrolatum is highly satisfactory in more advanced or chronic stages. In all cases of atopic dermatitis, the article says, it is well to put the patient on a simple elimination diet, which includes substitutes for cow's milk and the administration of vitamins A, D and C.

Health is something that all men desire and there is no limited supply for which nations must compete. Public health work carries no threat to anybody, anywhere. Cancer and scarlet fever have no political ideology. Raymond B. Rosdick, Am. J. Pub. Health, Jan., 1948.



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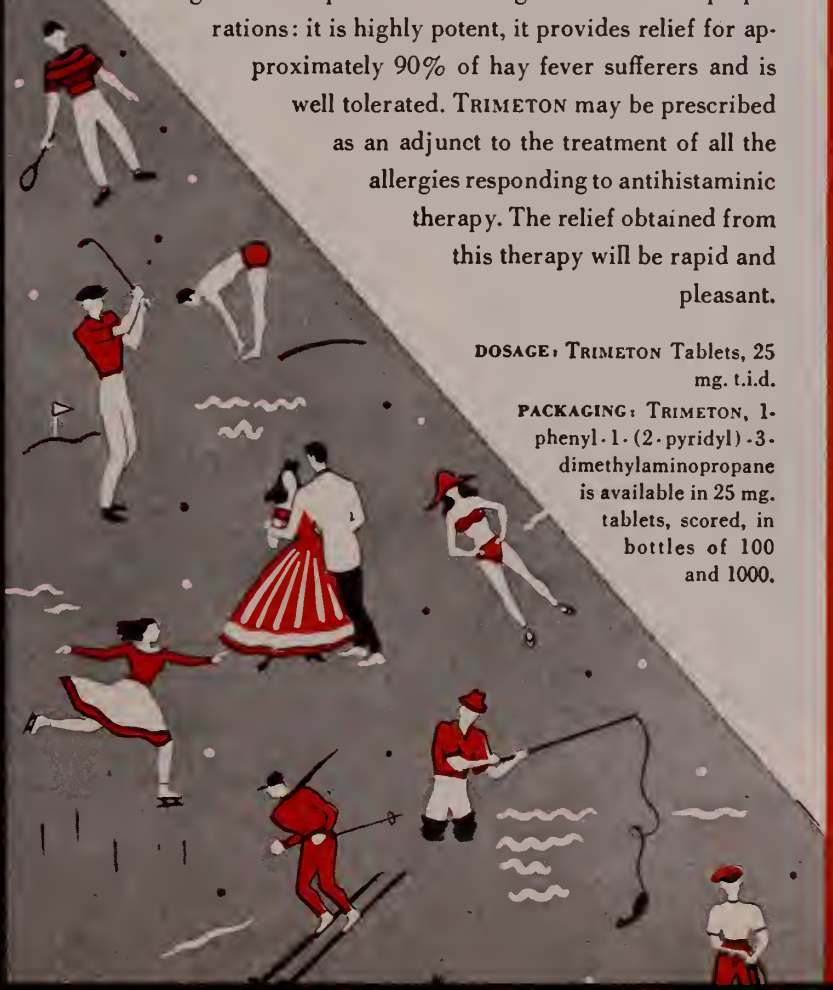
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WOMEN PAST 49 RESPOND BEST TO TREATMENT FOR CANCER OF CERVIX

Women past 49 respond more favorably to treatment for cancer of the cervix than do younger women, two physicians of the Mayo Clinic, Rochester, Minn., have found in a study made of 3,798 patients at the clinic from 1915 through 1944.

Writing in the July 10 issue of The Journal of the American Medical Association, the physicians — Harry H. Bowing and Robert E. Fricke — say that "the patient more than 49 years of age has a definitely favorable factor influencing the five year cure rate."

Women 49 or older responded better to all types of treatment, except that younger women were more able to withstand the effects of surgery.

Twenty-nine per cent of the women between the ages of 30 and 49 who were treated before 1940 and who were traced by the physicians were living five or more years after leaving the hospital. In the 40 to 69 group, nearly 37 per cent were living five or more years after leaving the hospital.

The majority of patients with cancer of the cervix are in the menopausal years of their lives, the study shows. About two thirds of the entire group were from 40 to 59 years of age and only a few patients were under 30 or over 69.

The importance of early treatment, systematic examination after treatment, individualized therapy, and the harmful effects of treatment by inadequate methods were used, the type being determined by the stage of the disease, the patient's condition and previous treatment, and other factors:

(1) Radium therapy (2) Roentgen therapy (3) Surgery (4) Surgery, radium therapy, and roentgen therapy (5) Combined radium therapy and roentgen therapy (6) Surgery and radium therapy, and (7) Surgery and roentgen therapy.

Combined methods are often more successful than any method used alone, the study points out.

The importance of early treatment is shown by the fact that among the patients at the clinic from 1915 through 1939, 65 per cent of those treated in an early stage of the disease and who were traced by the physicians were living five years after leaving the clinic.

Emphasizing the importance of systematic examination after treatment, the physicians say:

"The importance of a well-planned follow up system cannot be overstressed. We recommend re-examination every three or four months for the first post-treatment year; every six months for the second post-treatment year; and every year thereafter."

Stressing the adaptation of therapy to the needs of the individual patients, the physicians comment:

"It seems reasonable that by a combination of selected methods in proper sequence the most good can be obtained for the patient. So far, there are no mass production procedures that will effectively control the malignant disease."

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Proceedings of the Society of American Bacteriologists,
47th general meeting, May 13-17, 1947

A series of patients was treated intranasally with local penicillin, *500 units per cc.*, for 5 consecutive days. At the end of this time, the bacteria count was reduced from an average of 7,363 per cc. of nasal washings to the amazingly low average of 42.

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BOOK REVIEWS



PRACTICAL CLINICAL PSYCHIATRY: By Edward A. Strecker, A.B., A.M., Litt.D., LL.D., M.D., Professor of Psychiatry, School of Medicine, University of Pennsylvania. Franklin G. Ebaugh, A.B., M.D., Professor of Psychiatry, University of Colorado, School of Medicine, Director, Colorado Psychopathic Hospital. Jack R. Ewalt, M.D., Professor of Neuro-Psychiatry; Director, Galveston State Psychopathic Hospital, University of Texas Medical Branch. Section on Psychopathologic Problems of Childhood: By Leo Kanner, M.D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine, Sixth edition. The Blakiston Company, Philadelphia and Toronto 1947; 476 pages.

Psychiatric orientation from a textbook requires a special approach to the reader. The authors present their subject in a well organized teaching manner. Personality development and methods of examination are discussed first, followed by an elaboration of classification of the psychiatric states. This detailed classification does much to clarify the following discussions. The largest part of the book deals with the psychoses, oganic and non-organic, which precedes a discussion of the psychoneuroses. Such an arrangement seems more suited for instruction in that a firm grasp of psychotic principles tends to prepare for better understanding of psychoneurotic principles. Too little space, however, is devoted to the psychoneuroses of which the average physician sees in the largest numbers. There are brief discussions of childhood psychiatric problems.

The acceptance of this book is indicated by its publication in the 6th edition. In general, this is a worthwhile psychiatric text, written from the practical experiences of the authors in an easily followed style of language. J.W.F.

THE HEALTHY HUNZAS: By J. I. Rodale, Editor of the Organic Gardening Magazine, author of Pay Dirt. With 16 illustrations from original photographs supplied by Capt. C. J. Morris. Emmaus, Pa., Rodale Press, 1948. 257 pages. Price $2.75.

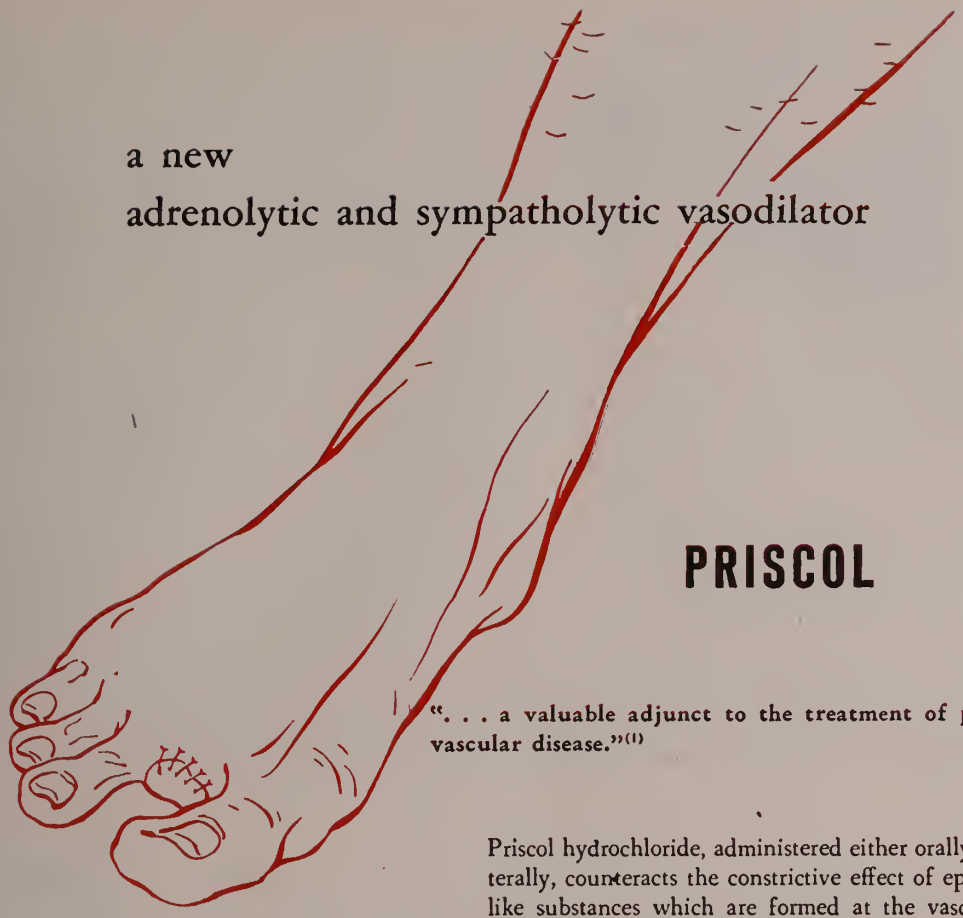
In the Healthy Hunzas, Mr. Rodale gives an interesting account of the life, habits, and history of the inhabitants of Hunza, an exceedingly remote and isolated province in the mountainous country of northern India, lying in the Himalayas between Afghanistan and China and almost on the threshold of Russia. The reader's pleasure is in no way lessened by reason of the fact that Mr. Rodale has never visited Hunza; and his book, therefore, is a compilation of the thoughts, writings, and observations of others.

Mr. Rodale uses the vigor of these people and their comparative lack of the ordinary human diseases and ills to preach his Gospel of organic farming, to which factor alone he ascribes their phenomenal health and hardihood. In attempting to prove this theory he draws freely upon the scientific experiments and writings of two distinguished Englishmen, Sir Robert McCarrison, physician, who spent almost a decade in Hunza, and Sir Albert Howard, mycologist and botanist, who did not visit Hunza but who worked in India and performed agriculture experiments there. However, Mr. Rodale draws conclusions in support of his theory beyond the claims of both of these eminent men.

In several resounding indictments he takes the medical profession in general to task for not embracing his theory and acting as propagandists for his idea that organic farming is a panacea. He accuses the Doctors of being myopically indifferent to the manner in which foods are grown and states, "The Doctor is too much involved in the morasses of disease and physic, to be

(*Continued on page* 56)

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When Mr. Rodale adheres to the subject of organic farming and the benefits to be derived therefrom in contrast to the widespread reliance on chemical fertilizers and poison sprays, he writes authoritatively and convincingly. However, when he invades the field of infection and immunity, and susceptibility to disease, as well as the reasons underlying absence of disease, he is preaching on a subject in which he has no training, experience or qualification. He states that the Hunza do not know illness because of the simple, wholesome method they use in growing their food, and yet we read on page 110 that trachoma, glaucoma and cataracts are unhappily prevalent among them.

Also in this book he cites an example which demonstrates that there exist in nature unknown — and, perhaps, unknowable-constituents to life; but he does not hesitate to construe one known factor — that of the farming methods practiced by the Hunzukut — as responsible for all the good health, and vigor to which he is heir. Although he mentions the factors of extreme isolation and complete lack of contact with other human beings, as well as the unstudied one of the geological formation underlying the soil and the fertilization of that soil by glacier-ground silt of unknown composition, he neglects them in solving the mystery of the healthy and happy Hunzukut. A. W. B.

HEART: A Physiologic and Clinical Study of Cardio-Vascular Disease; By Aldo A. Luisada, M. D., Instructor in Physiology and Pharmacology, Tufts College Medical School, Lecturer in Medicine; Lecturer, Postgraduate Division, Tufts College Medical School, Associate in Medicine, Beth Israel Hospital, Boston, Mass. Former Professor of Medicine, Ferrara, Italy; with a Forward by Herrmann L. Blumgart, Physician-in-Chief, Beth Israel Hospital, Professor of Medicine, Harvard Medical School; The Williams and Wilkins Company, Baltimore, 1947; Price $10.00; 653 papes.

A well written addition to the literature on cardiology is presented in this new book. The author progresses through the field in an orderly organization of embryology, anatomy, physiology, symptomatology, technical study, diseases of the heart, pharmacology, and dietetics. Normal functions and cardiac manifestations are reviewed before considering the clinical study of the patient. The technical study entails the basic factors of the electrocardiogram and brief descriptions of phonocardiography, phlebograms, and other technical photographic procedures. Other simpler diagnostic procedures are discussed. A considerable section is devoted to disease of the heart with a correlation of the technical studies with pathology and clinical findings. The book concludes with a short generalized summary of the management of the cardiac patient.

The author's style is clear and informative. He

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avoids controversial subjects except where it is necessary to stress certain viewpoints. There are numerous charts, diagrams, sketches and photographs to explain conditions not easily described.

J.W.F.

TREATMENT OF HEART DISEASE: By William A. Brams, M.S., M.D., Ph.D., Associate Professor of Medicine, Northwestern University Medical School, and Attending Physician, Michael Reese Hospital, Chicago, W. B. Saunders Company, Philadelphia & London, 1948. Price $3.50. 125 pages.

Dr. Brams has written a systematic and practical guide to the treatment of heart disease, based upon his own experience and methods. About one third of the book describes the pharmacologic action of the usual cardiovascular drugs. The author covers the usual cardiovascular diseases briefly and informatively. A single chapter discusses the treatment of congestive heart failure in a practical manner. Other individual chapters cover endocrine and metabolic disorders, pregnancy, surgery, and neurocirculatory asthenia. In general, however, diseases of the heart, are grouped according to anatomical divisions. There are many helpful hints throughout the text aside from the usual clinical discussions. These include diabetic management and obesity. Discussion of the disturbances in rate and rhythm are quite simple and understandable. This book appears to be quite a valuable guide where

(*Continued on page* 59)

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Medical Protective Co., Fort Wayne, Ind. 22
Physician Casualty Co., Omaha, Neb. 57

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Abbott Laboratories, North Chicago, Illinois 31
Ames Co., Inc., Elkhart, Ind. 57
The Arlington Chemical Co., Yonkers, N. Y. 32, 46
Armour Laboratories, Chicago 9, Ill.
Ayerst, McKenna & Harrison Ltd., New York 16 11
Barlow-Maney Laboratories, Inc., Cedar Rapids, Iowa ... 37
Bilhuber Knoll Corp., Orange, N. J. 56
Borcherdt Malt Extract Co., Chicago 12, Ill.
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Ciba Company, Summit, N. J. 4, 55
Commercial Solvents Corp., Terre Haute, Ind. 16
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Holland-Rantos Co., Inc., 551 Fifth Ave., New York .. 45
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Bellevue Place, Batavia, Ill. 59
Costeff Sanatorium, Peoria, Ill. 62
Douglas Park Hospital, Chicago 23 59
Edward Sanatorium, Naperville, Ill. 60
Michell Farm, Peoria 60
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 61
North Shore Health Resort, Winnetka 62
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Book Reviews (Continued)

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J.W.F.

PSYCHOBIOLOGY AND PSYCHIATRY: By Wendell Muncie, M. D., Practicing Psychiatrist: Chairman, Medical Advisory Board, Seton Institute, Baltimore, Md.; Associate Professor Psychiatry, John Hopkins University: Consultant in Psychiatry, U.S.V.A.: Second Edition. With 70 illustrations. The C. V. Mosby Company, St. Louis, 1948. Price $9.00. 620 pages.

The content of this book contains the principles and teachings of Adolph Meyer as they are applied at the Henry Phipps Psychiatric Clinic at the John Hopkins Hospital. There are three parts to this comprehensive volume: — Phychobiology and the study of human behavior; The Pathology and psychiatry of abnormal behavior; and Treatment. The author concisely goes through the historical development of the schools of psychiatric thought with brief condensations of the views of such well known names as Freud, Kraepelin, Meyer, and many other outstanding contributors to this field. Meyer's terminology is used and explained. The procedures for personality study and examination are written in detail. Major and minor reactions are studied. The many psychiatric symptoms are approached with clear description and handled well from the standpoint of the physician's orientation. Of special importance is the detailed section on psychobiology. Another valuable feature contained in this book is the method of the physician's approach to treatment, both personal and by the group, and by other means such as; drugs, shock, nursing, environment, etc.

To those interested in psychiatry this book should be quite worthwhile from the standpoint of its teaching features from one of our outstanding psychiatric clinics.

J.W.F.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

GENERAL ENDOCRINOLOGY: By C. Donnell Turner, Ph.D., Associate Professor of Zoology at Northwestern University. New, 1st edition. 604 pages with 164 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.75.

EATING FOR HEALTH: By Pearl Lewis, B. S., Consultant Dietitian. 121 pages. The MacMillan Company, 60 Fifth Avenue, New York, July 27, 1948. $2.25.

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GYNECOLOGICAL AND OBSTETRICAL ANATOMY. By C. F. V. Smout, M. D., M. R. C. S., Assistant Professor, Department of Anatomy, Sub-Dean and Tutor, Faculty of Medicine, University of Birmingham. With chapters on The Histology of the Female Reproductive Tract and Its Endocrine Control by F. Jacoby, M.D., Ph.D., Lecturer in Histology, Department of Anatomy, University College, Cardiff; formerly, Department of Physiology, University of Birmingham. Second Edition. 248 pages. The Williams & Wilkins Company, Baltimore, 1948. $11.00.

ESSENTIALS OF PUBLIC HEALTH: By William P. Shepard, B. S., M. D., M. A., With the collaboration of Charles Edward Smith, M. D., D. P. H., Rodney Rau Beard, M. D., M. P. H., Leon Benedict Reynolds, A.B., Sc.D. With a foreword by Ray Lyman Wilbur, M.D., LL.D., S3.D., Chancellor, Stanford University, Ex-secretary of the Interior, formerly president of Stanford University. 600 pages. J. B. Lippincott Company, Philadelphia, London, Montreal, July 9, 1948. $5.00.

TWENTIETH CENTURY SPEECH AND VOICE CORRECTION: Edited by Emil Froeschels, M. D., President, International Society for Logopedics and Phoniatrics; President, New York Society for Speech and Voice Therapy. 321 pages. Philosophical Library, New York.

HUMAN NUTRITION: By V. H. Mottram, M. A. (Cant.) Formerly Professor of Physiology at King's College of Household and Social Science, University of London. The Williams & Wilkins Company, Baltimore, 1948. 151 pages. $2.75.

MODERN DRUGS IN GENERAL PRACTICE: By Ethel Browning, M.D., Ch.B., Second Edition. The Williams & Wilkins Company, Baltimore, 1947. 223 pages. $4.00.

RECENT ADVANCES IN SURGERY: By Harold Edwards, C. B. E., M. S., F. R. C. S., Surgeon and Lecturer in Surgery, King's College Hospital, London; Surgeon, Evelina Hospital for Sick Children; Dean, Medical School, King's College Hospital; Former Consulting Surgeon, Central Mediterranean Forces. Third Edition. 437 pages. 131 illustrations, The Blakiston Company, 1012 Walnut Street, Philadelphia 5, and Toronto 2. Canada, June 16, 1948. $6.50.

STANDARD RADIOGRAPHIC POSITIONS: By Nancy Davies, M. S. R., C. T., Senior Radiographer, Malvern General Hospital, Malvern, Formerly Sgt. Radiographer-in-charge, Queen Alexandra Military Hospital, Millbank, London (attached No. 18 Coy, R. A. M. C.) and Radiographer-in-charge, Royal Survey County Hospital, Guildford, Royal Gwent Hospital, Newport, Caernarvonshire and Anglesey Infirmary, Bangor, Royal Infirmary, Worcester and Radiographer, Royal Infirmary, Derby, and Ursel Isenburg, M. S. R., Radiographer, Royal Free Hospital, London, Formerly radiographer, Willesden

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General Hospital, London, London Homeopathic Hospital, Research Worker, Institut Muncipal d'Electro-Radiologic (Prof. Zimmern), Paris, and Radiographer, Rudlof Virchow Hospital, (Dr. G. Bucky), Berlin. Second Edition. 223 pages. The Williams and Wilkins Company, Baltimore, 1948. $6.00.

PRINCIPLES GOVERNING EYE OPERATING ROOM PROCEDURES: By Emma I. Clevenger, R. N., Supervisor, Eye Operating Room, New York Eye and Ear Infirmary, New York City. 215 pages. The C. V. Mosby Company, St. Louis, 1948. $5.50.

TREATISE ON SURGICAL INFECTIONS: By Frank Lamont Meleney, M.D., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University, Associate Visiting Surgeon, Presbyterian Hospital, New York, Oxford University Press, New York. 713 pages. Published July 1, 1948. $12.00.

A COURSE IN PRACTICAL THERAPEUTICS: By Martin Emil Rehfuss, M. D., F. A. C. P., Professor of Clinical Medicine and Sutherland M. Prevost, Lecturer in Therapeutics, The Jefferson Medical College, Philadelphia, Attending Physician, The Jefferson Medical College Hospital, Philadelphia and F. Kenneth Albrecht, M. D., Formerly clinical director, U. S. Marine Hospital, Baltimore, Md., and Co-director Division of Tuberculosis Control, Kansas State Department of Health, and Alison Howe Price, A. B., M. D. Assistant Professor of Medicine, The Jefferson Medical College, Philadelphia, Assistant Physican to The Jefferson Medical College Hospital, Philadelphia, The Williams and Wilkins Company, Baltimore, 1948. 824 pages. $15.00.

PRACTICE OF ALLERGY: By Warren T. Vaughan, M. D., Richmond, Virginia, Revised by J. Harvey Black, M. D., Dallas, Texas; Second Edition; 1132 pages. The C. V. Mosby Company, Saint Louis, 1948. $15.00.

Although tuberculosis is extremely serious in infancy, the disease is relatively mild later in childhood. It is also true that the treatment of children with a primary complex, such as that afforded by a sanatorium, has no effect on the development of progressive tuberculosis in later life. Joseph D. Wassersug, M.D., New England J. Med., July 13, 1947.

If the head of a family is stricken with tuberculosis the family's resources are exhausted in about one year. After that society takes care of the victim and his dependent children, and after his death gives his widow a pension. The expenditure in taking care of the results of the disease far exceed the money spent for its eradication. James H. Hutton, M.D., Illinois M. J., Apr., 1947.

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PROTEIN THERAPY UNSUCCESSFUL FOR PEPTIC ULCER, SAY DOCTORS

Protein hydrolysate, predigested protein, is of little value in treating peptic ulcer, five Cleveland, Ohio, doctors report.

Writing in the August 7 issue of the Journal of the American Medical Association, the doctors — Edward E. Woldman, David Fishman, Richard S. Knowlton, A. Ashley Rousuck, and Willard C. Stoner — describe their findings from a study made at the department of gastroenterology, St. Luke's Hospital, Cleveland.

Protein hydrolysate therapy, also known as amino acid diet because the protein is made up of amino acids, is one of the comparatively new treatments for peptic ulcer and one which has been regarded as extremely promising.

Developed by Dr. Frank Co Tui of the New York University College of Medicine and the New York University Division of Surgery, Bellevue Hospital, New York City, and his associates, it consists of regular feedings of protein hydrolysate and carbohydrates for a period of two or three weeks. Supplementary vitamins are also given.

Many of Dr. Co Tui's patients were relieved of pain within 24 hours after the treatment was begun. Even in "intractable" cases — those who had not improved on complete bed rest and strict Sippy treatment — the ulcers became inactive. The alkaline Sippy powders neutralize excess acidity in the stomach and, combined with a mild, soothing diet, have long been used for treating peptic ulcer.

Dr. Co Tui's theory was that the high caloric and high protein diet rehabilitated the strength and body weight of the ulcer patient as well as prevented overacidity in the stomach. Many peptic ulcer patients, he found, were deficient in protein.

Such protein deficiency is brought about by an unbalanced choice of foods rather than by the ulcer patient's inability to retain or digest proteins in ordinary forms, the Cleveland study indicates. None of the 22 peptic ulcer patients treated in the study showed protein deficiency.

To test the therapy, the doctors administered a continuous drip of 10 per cent protein hydrolysate for 14 days through a tube inserted into the patient's stomach through the nose.

Although protein hydrolysate lowers the free acidity as long as the preparation remains in the stomach, they found that its aftereffect is to raise the patient's stomach acidity to a higher level than it was before treatment.

"When protein hydrolysate leaves the stomach," they say, "there is apparently a stimulation of the production of more free acid to higher level than the original state.

"The presence of the amino acids in the upper part of

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the small intestine apparently causes a hormone to be liberated which stimulates the secretion of hydrochloric acid."

Protein hydrolysate also ceases to counteract stomach acidity after being given in repeated small doses, they explain.

In most of the 22 patients, free hydrochloric acid was observed in the stomach despite the continuous drip of protein hydrolysate. Ulcer pain continued for 24 to 72 hours, and in some patients the pain recurred later during the treatment. A month after treatment was discontinued, eight patients had ulcer symptoms again.

ANTIBODY RESPONSE AFTER PROMPT TREATMENT

Immunity to those diseases capable of conveying it by a single attack is usually dependent upon adequate stimulation of antibody production by a specific antigen. The longer the stimulation the more effective is the immunity. For example, a lasting protection against future infection usually follows such diseases as measles, typhoid fever, diphtheria and other diseases in which specific antigenic substance is released into the blood or tissues of the infected host. In addition to the treatment applied in any of these diseases, antibody response to such stimuli is still a contributory factor to recovery and the production of active immunity. So it seems reasonable to assume that early and sustained treatment with potent specific antitoxin or chemotherapeutic or antibiotic agents will overcome the invader so promptly that this contributory factor will be impaired or destroyed.

In the search for reasons why we encounter so much diphtheria — and measles — in adults in recent years, the impression, which is not new, that this moy be one of many explanations, is being considered more than ever before. In fact evidence has been obtained from a few studies that it is possible for chemotherapy to be so successful, and infection can be overcome so promptly that the normal defense mechanism does not have a chance to get started. Obviously under such a condition no immunity can be developed and a second attack may consequently be expected whenever such an individual is exposed at a later time. — *Int. Med. Dig.*

Every visit to the clinic or the doctor's office, every visit by the public health nurse, is health education, for the visit provides the most powerful type of learning, namely, experience. If the experience is not satisfying, there will be a tendency to avoid seeking health and medical care the next time that the individual or a member of his family needs it. Mayhew Derryberry, Ph.D., Pub. Health Rep., Nov. 14, 1947.



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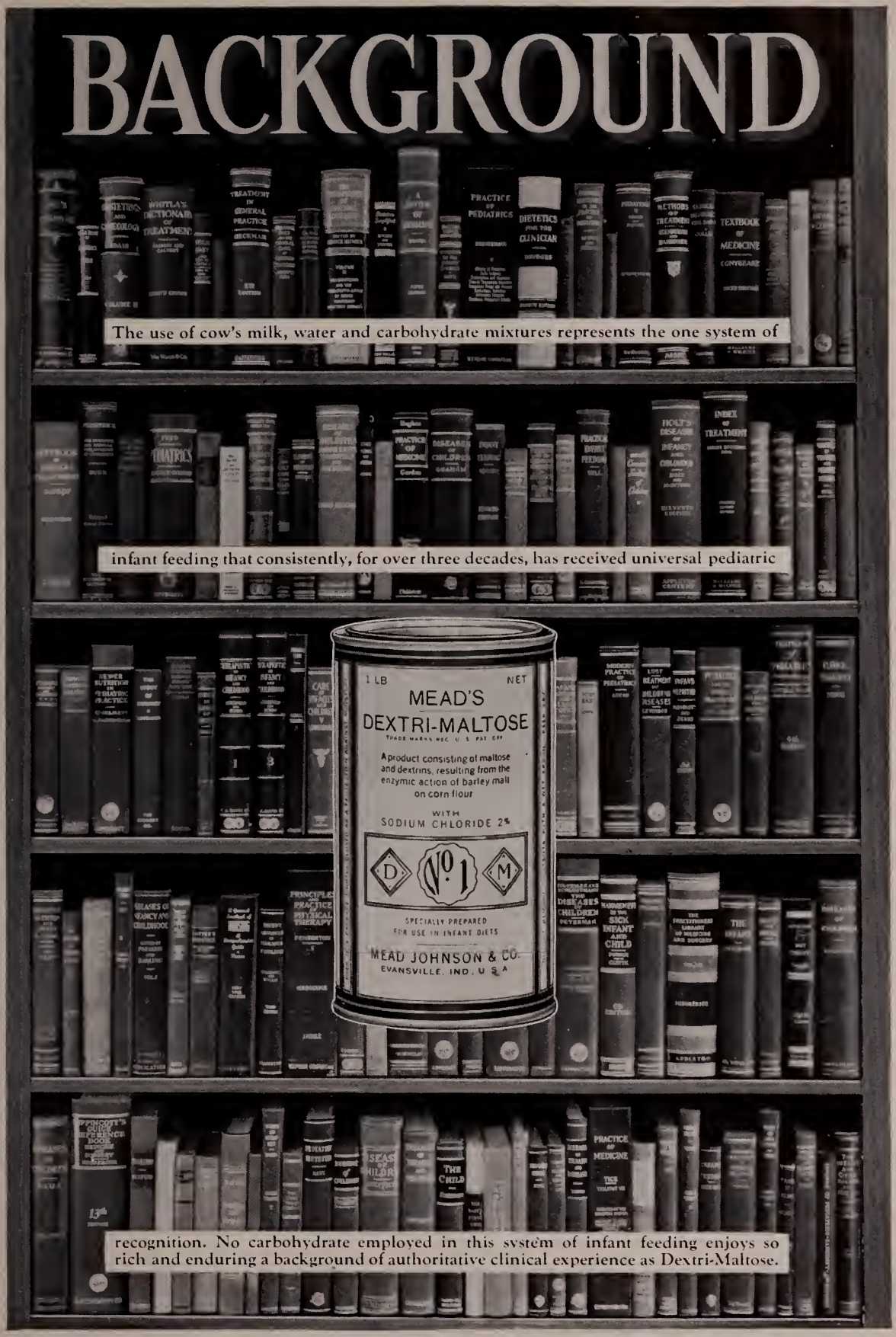
DIAGNOSIS OF POLIOMYELITIS

It is convenient to discuss the diagnosis of poliomyelitis under the conventional headings of history, symptomatology, physical findings and laboratory data. A careful history as to the mode of onset and duration and type of symptoms is important from the point of view of differential diagnosis. Unlike many other acute communicable diseases, a history of exposure, or lack of it, to a previously known case is not very helpful. A history of another member of the family having been ill with an acute febrile illness some time within the limits of the incubation period may be of some significance, but the total number of cases which can be traced to direct contact with a known case is not very great. The incubation period is estimated to vary from four to seventeen days with an average duration of approximately ten days.

As a rule the onset of the disease is acute, with fever, headache, malaise and perhaps nausea and vomiting, an onset which differs little from that of many other acute infections such as tonsillitis, scarlet fever, influenza, etc. Either diarrhea or constipation may be present. The fever of poliomyelitis is usually of moderate degree averaging from 101 to 103 F. Temperatures above this at the onset of symptoms should make one suspicious that poliomyelitis is not the causative factor.

During the 1946 season many of us were impressed with the epidemic of sore throats which paralleled the poliomyelitis epidemic. The number of individuals who experienced such acute febrile illness was far greater than the number of poliomyelitis patients. While no proof was available, nevertheless it was difficult to escape the suspicion, at least, that these may have been actual infections with the poliomyelitis virus, but in which nature's defensive mechanism was successful in preventing the virus reaching the central nervous system. It would have been interesting to have had the means at hand to attempt to recover the virus from the throats or stools of some of these patients, or to have determined the presence of neutralizing antibodies from blood specimens at the time of the illness and several weeks later. Diagnosis of poliomyelitis in this possible subclinical or inapparent group cannot be made without the aid of such studies.—Lee Forrest Hill, M. D., in *J. Iowa State Medical Society.*

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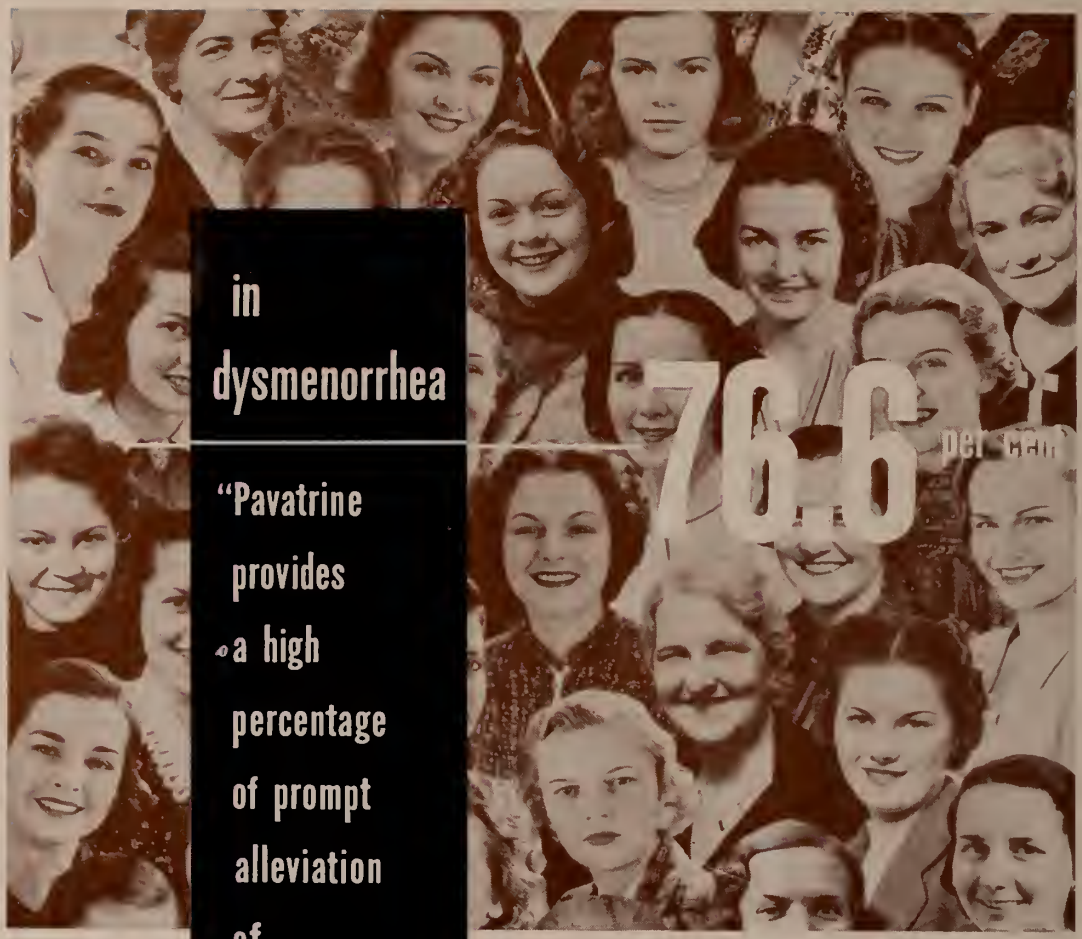
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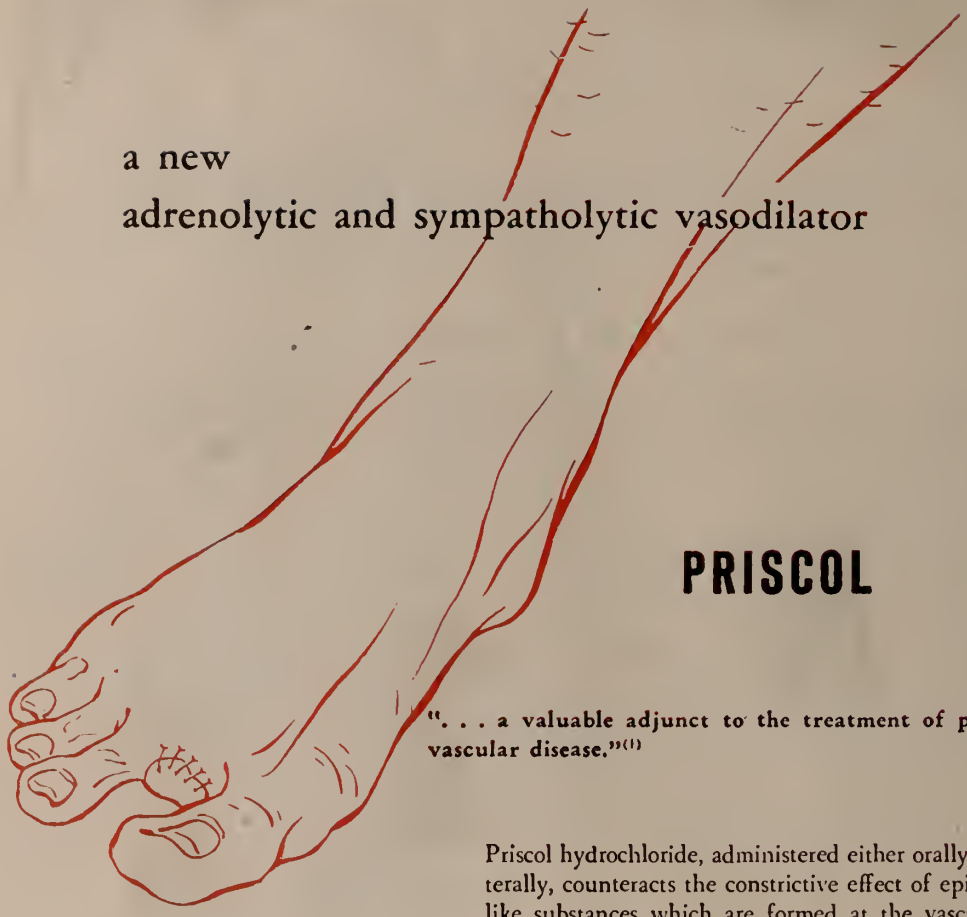
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1. Grimson, K. S., Marzoni, F. A., Reardon, M. J., and Hendrix, J. P.: *Surg.*, 23:728, 1948.

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TABLE OF CONTENTS

OCTOBER, 1948
Vol. 94, No. 4

ORIGINAL ARTICLES

Treatment of Influenzal Meningitis, *Abraham Levinson, M.D.*, Chicago 227

The Management of Labor, *L. A. Calkins, M.D., Ph.D.*, Kansas City, Kansas 231

Studies in the Oral Administration of Penicillin, *Italo F. Volini, M.D., Wm. Hoffman, M.D., J. R. Hughes, M.D.,* and *J. R. Peffer, M.D.*, Chicago .235

Routine Technic of a Typical Rhinoplasty, *Samuel Fomon, M.D.*, and *Victor R. Syracuse, M.D.*, New York City 242

The Role of Developmental Diagnosis in Pediatrics, *Catherine S. Amatruda, M.D.*, New Haven, Conn. 251

The Constitutional Emotional and Cultural Factors Producing Mental Deficiency, *Hans Neuer, M.D.*, Lincoln 255

Additional Observations in Neostigmine Therapy, Case Report, *Burton J. Winston, M.D.*, Waukegan 261

EDITORIALS

The General Practitioner 209

Hospital Construction in Illinois Downstate Areas .211

Your Dues Have Been Raised 211

Medical Examination Procedure under 1948 Selective Service Act, *Paul G. Armstrong* 213

Dedication 213

Council Meeting Minutes, August 29, 1948 263

Book Reviews 60

MEDICAL ECONOMICS

The Pathologist in Group and Hospital Practice....215

MEDICO-LEGAL BRIEFS

Possible Liability in Operations to Produce Sterility.217

STATE DEPARTMENT OF PUBLIC HEALTH

The Course of the Maternal Death Rate in Illinois .219

CORRESPONDENCE

Organization of Auxiliaries in Illinois 224

Illinois National Guard Medical Department Letter .224

Payment Under the EMIC Program 226

Prizes for Research in Urology 226

Announcement of Van Meter Prize Award 226

Tests for Ophthalmologists 226

PHYSICAL MEDICINE ABSTRACTS 44

NEWS OF THE STATE 268

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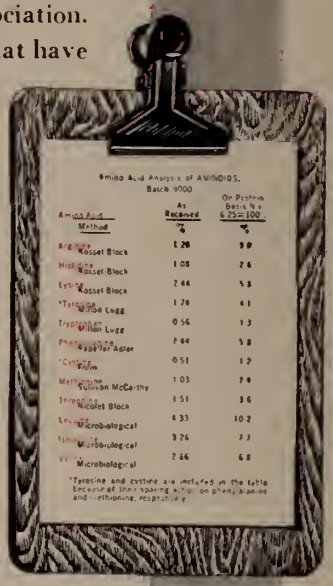
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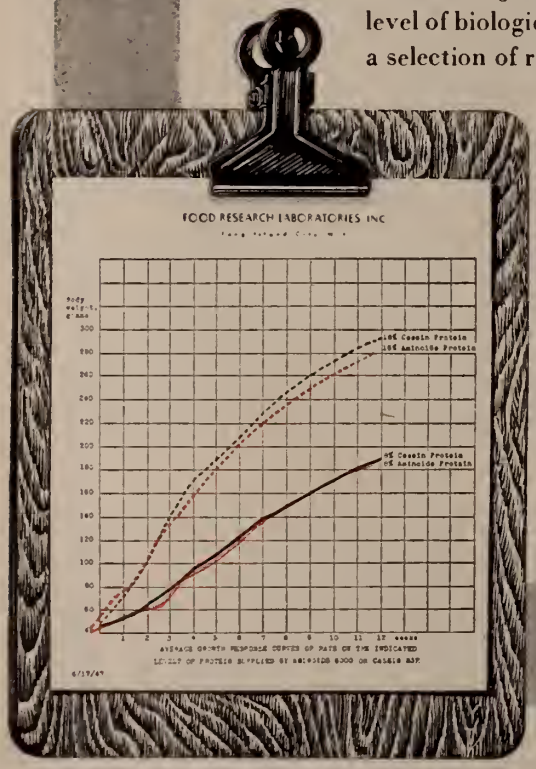
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Amino Acid — Method	As Received %	On Protein Basis % N 6.25=100 %
Arginine — Kossel Black	1.26	9.9
Histidine — Kossel Black	1.08	7.6
Lysine — Kossel Black	2.44	5.8
*Tyrosine — Sullivan Lugg	1.76	4.1
Tryptophan — Sullivan Lugg	0.56	1.3
Phenylalanine — Csonka-Aslor	2.64	5.8
*Cystine — Palm	0.51	1.2
Methionine — Sullivan McCarthy	1.03	2.4
Threonine — Nicolet Black	1.51	3.6
Leucine — Microbiological	4.33	10.2
Isoleucine — Microbiological	3.26	7.7
Valine — Microbiological	2.66	6.8

*Tyrosine and cystine are included in the table because of their sparing action on phenylalanine and methionine, respectively.

CAMINOIDS has a biological value approximately equivalent to that of casein . . . long recognized as a high-quality protein standard. It supplies all of the amino acids recognized as essential to a high level of biological activity. Derived from a selection of rich protein sources: liver, beef muscle, wheat, soya, yeast, casein, and lactalbumin.



SUPPLIED: Bottles containing 6 oz.

No change has been made in the product. Your patients may continue to receive bottles labeled Aminoids until druggists' present stocks are exhausted.

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Illinois State Medical Society

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(Continued on page 10)

(County Officers Continued)

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All you could ask for in an oral estrogen: that has been the goal of Parke-Davis research in developing MENAGEN Capsules. Here is a standardized estrogen with definite pharmacologic activity. Estrogens in MENAGEN are not combined with other chemical radicals but are in free estrogenic form.

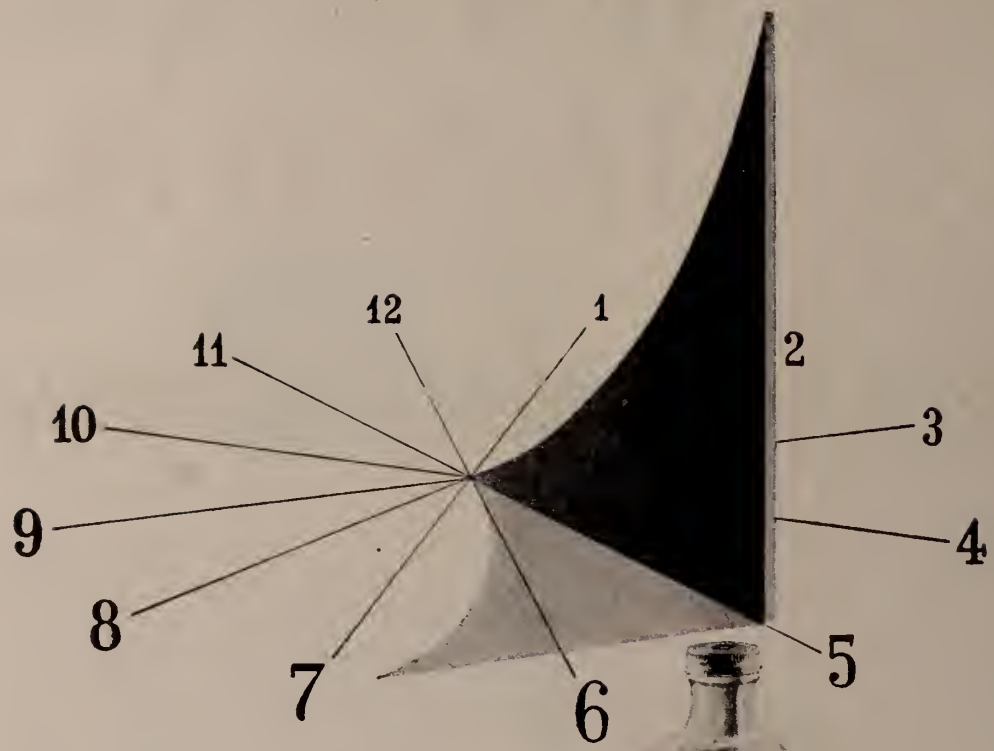
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Each MENAGEN Capsule contains the estrogenic equivalent of 10,000 international units of ketohydroxyestratriene. Bottles of 100 and 1000 capsules.

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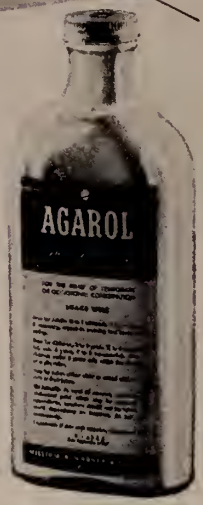
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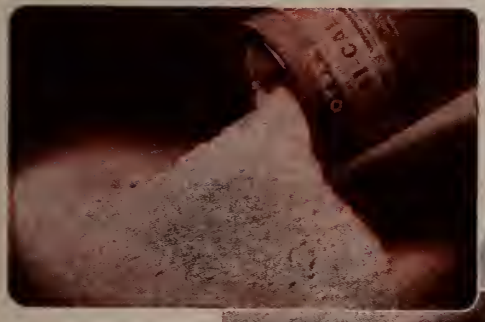
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SUPPLIED IN 4-OUNCE CONTAINERS
EACH AL-SI-CAL TABLET CONTAINS
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Dentistry, in the story of its evolution from "tooth tinkering" to modern methods, cites the jeweler's "fiddle-bow" drill as the first of America's mechanical devices for the preparation of cavities.

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ECONOMICAL Cost-to-patient—about a penny a day for antirachitic protection of average infant. In convenient, palatable Liquid form—dropper administration.

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One of White's Integrated Pediatric Vitamin Formulas

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Dienestrol in the menopausal syndrome

CLINICAL STUDIES SHOW:

Less withdrawal bleeding

"Occurrence of withdrawal bleeding is relatively infrequent following the use of dienestrol."

Finkler, R. S. and Becker, S.: Dienestrol: A New Synthetic Estrogen, J. A. M. A., *1*:152 (Aug.) 1946.

Well tolerated

"Dienestrol was very well tolerated by all menopausal patients."

Rakoff, A. E., Paschkis, K. E. and Cantarow, A.: A Clinical Evaluation of Dienestrol, A Synthetic Estrogen, J. Clin. Endocrinol., *7*:688 (Oct.) 1947.

Low toxicity

"This low incidence of nausea [1.3 per cent] is . . . in contrast with that encountered during treatment with other synthetic estrogens."

Finkler, R. S. and Becker, S.: "A Preliminary Evaluation of Dienestrol in the Menopause, Am. J. Obst. & Gynec., *53*:513 (Mar.) 1947.

Low recommended dosage

"Clinical trials...indicate that doses of 0.2 to 0.5 mg. daily are adequate, dependable and tolerated . . ."

Sikkema, S. H. and Sevringhaus, E. L.: Dienestrol: Another Synthetic Estrogen of Clinical Value, Am. J. Med., *2*:251 (Mar.) 1947.

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White's **DIENESTROL**

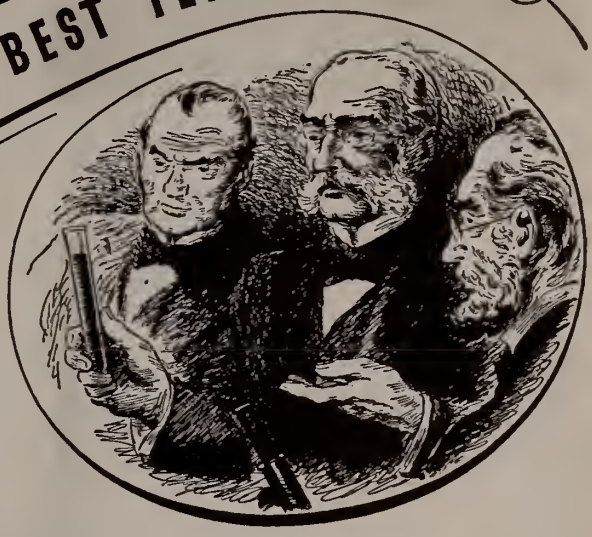
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Aqueous Suspension of Dienestrol—5 mg. per cc., 10 cc. vials.

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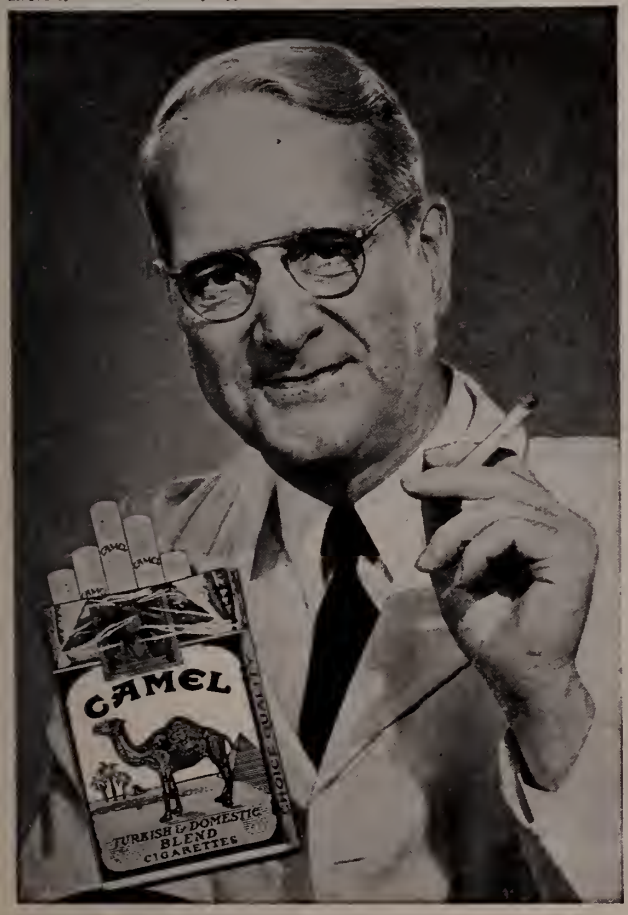


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proved it in public health

Carlos Finlay, of Cuba, a bacteriologist, believed that yellow fever was transmitted by the stegomyia mosquito. His original experiments did not provide definite proof of his theory. However, he continued his search in co-operation with Walter Reed and the Yellow Fever Commission. The work of the Commission finally proved that infected mosquitoes could transmit the fever. The public health preventive measures derived from these experiments were so successful that the fever in Cuba was under control within a year.

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MILLIONS of smokers who have tried and compared many different brands of cigarettes have found that cool, mild, flavorful Camels suit them best.

Try Camels on your "T-Zone"—T for Taste, T for Throat. See how your taste enjoys the rich, full flavor of Camel's choice, properly aged, and expertly blended tobaccos. See if your throat doesn't welcome Camel's cool, cool mildness.

Yes! Try Camels and see for yourself why, with thousands and thousands of smokers, Camels are the "choice of experience."

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According to a Nationwide survey!

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

Lanteen

FLAT SPRING DIAPHRAGM

Physician's package and complete description of the *New Technique* will be sent upon request.

Ethically promoted—Advertised only to the medical profession.



Accepted by the Council on Physical Medicine of the American Medical Association.

Easily Fitted—The Lanteen Flat Spring Diaphragm, collapsible in one plane only, is easily placed without an inserter.

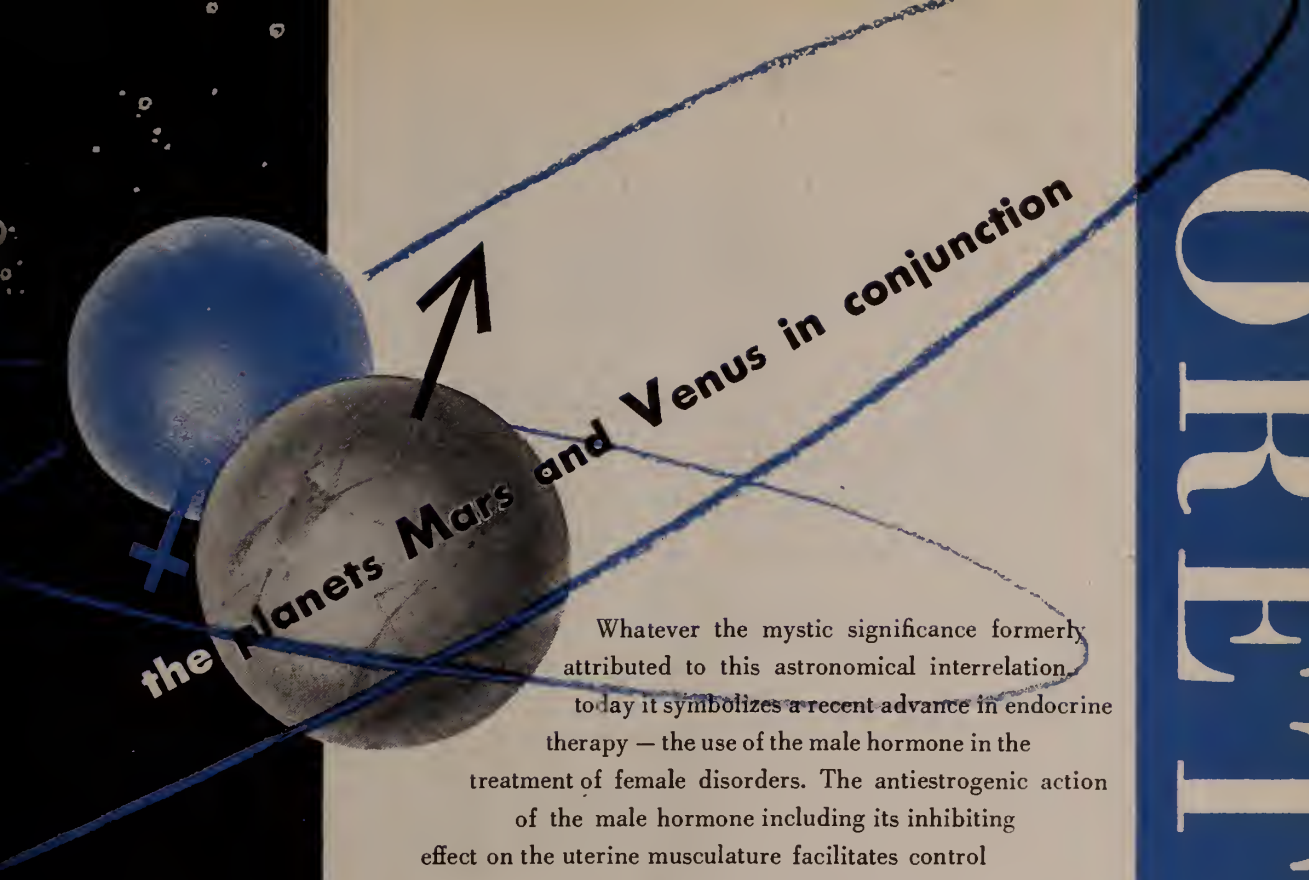
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Whatever the mystic significance formerly attributed to this astronomical interrelation, today it symbolizes a recent advance in endocrine therapy — the use of the male hormone in the treatment of female disorders. The antiestrogenic action of the male hormone including its inhibiting effect on the uterine musculature facilitates control of gynecologic disturbances.

ORETON-M

METHYLTESTOSTERONE U.S.P. XIII *tablets*

are effective — by mouth — in the management of dysmenorrhea and premenstrual distress, functional uterine bleeding and the menopause. In the puerperal patient ORETON-M* relieves breast engorgement, abolishes after-pains and inhibits lactation.

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puerperal morbidity reduced



Pelvicins*

[penicillin vaginal suppositories Schenley]

In a recent controlled study [1] of 1,573 obstetrical patients, the incidence of genital tract infections was reduced from 5.3 per cent to 2.3 per cent when penicillin vaginal suppositories were used. *A decline of 56.6 per cent!*

ADDITIONAL ADVANTAGES: PELVICINS (penicillin vaginal suppositories Schenley) shorten the hospitalization period; reduce nursing care required; are completely painless and nonirritating. These advantages suggest the value of their routine use in obstetrical procedure.

SIMPLICITY OF TECHNIQUE: Insert 2 PELVICINS (total, 200,000 units of penicillin) into posterior fornix of vagina with a sponge forceps, immediately after delivery of the placenta.

SUPPLIED: Boxes of 6 and 12 PELVICINS, 100,000 units each.

1. Pierce, R. R.: Am. J. Obst. & Gynec. vol. 55 (Feb.) 1948.

*Exclusive trademark. © Schenley Laboratories, Inc.



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PRICE REDUCTION: PELVICINS now cost your patients one-third less.



Developed to Serve Many Purposes



Short-acting Nembutal also has been developed to serve many purposes. In the 473 reports already published on Nembutal, more than 44 clinical uses for the drug have been reviewed. These reports, crystallizing the experience of physicians for more than 18 years, show that adjusted doses of Nembutal can achieve any desired degree of cerebral depression, from mild sedation to deep hypnosis. They show, too, that the dosage required is only about *one-half* that of many other barbiturates. Small dosage means less drug to be inactivated, reduced possibility of "hangover," shorter duration of effect, wide safety margin, and definite economy to the patient. Shown below is a partial list of indications for the use of Nembutal. Perhaps it will suggest new ways for you to employ the drug. Administration is a simple matter, for 11 different Nembutal products are available—all in convenient small-dosage forms. Write for new booklet, "44 Clinical Uses for Nembutal." ABBOTT LABORATORIES, North Chicago, Ill.

In equal oral doses, no other barbiturate combines

QUICKER, BRIEFER, MORE PROFOUND EFFECT *than*

NEMBUTAL®

(Pentobarbital, Abbott)

44 of Nembutal's Clinical Uses

SEDATIVE

Cardiovascular
Hypertension[1]
Coronary disease[1]
Angina[1]
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[3,1]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[5,4]

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[6]

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

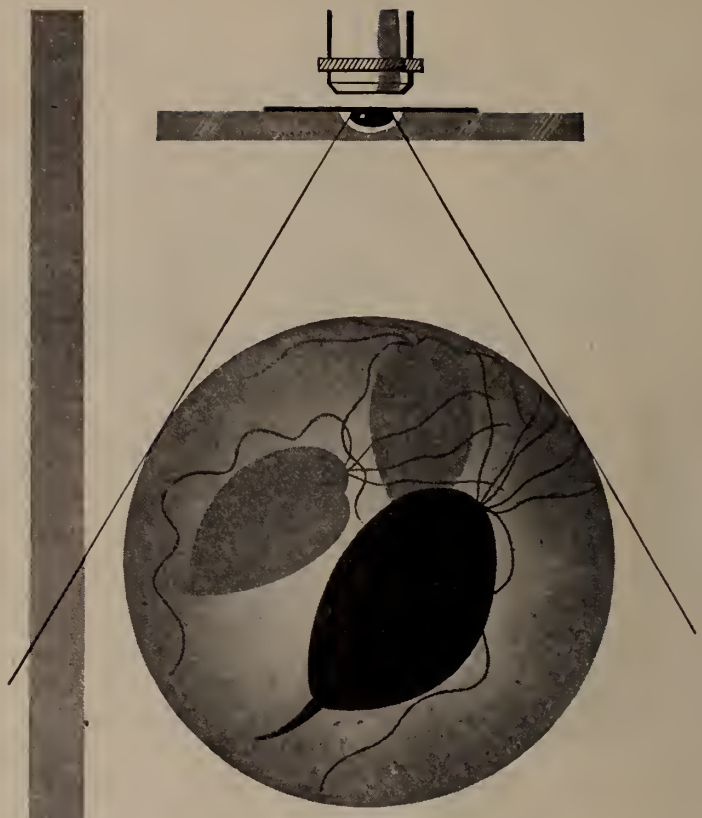
PEDIATRIC

Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Nembutal alone or
[1]Glucaphylline® and Nembutal,
[2]Nembutal and Belladonna,
[3]Ephedrine and Nembutal,
[4]Nembudeine®,
[5]Nembutal and Aspirin,
[6]with scopolamine or other drugs.

To combat the growth of pathogens in the vaginal secretions



The normal acid reaction of the vagina—a pH between 3.86 and 4.45—constitutes the chief natural defense against invasion of pathogens. Massengill Powder, by producing a pH of 3.5 to 4.5, thus counteracts the development of a more alkaline vaginal reaction which is favorable for the proliferation of trichomonas, monilia, staphylococci, streptococci and gonococci.

Massengill Powder, presenting boric acid, ammonium alum, berberine sulfate, phenol, menthol, thymol, eucalyptol and aromatics, is indicated in the management of trichomonas vaginitis, cervicitis, and other vaginal infestations by pathogens. It is a valuable adjuvant of proven efficacy in the treatment of leukorrhea, pruritus vulvae and nonspecific vaginitis. Its cleansing and deodorizing properties are also widely appreciated by the patient. Available in 3 oz., 6 oz., 1 lb. and 5 lb. jars.

SE-MO-CO

Massengill Powder

THE S. E. MASSENGILL COMPANY
Bristol, Tenn.-Va.
NEW YORK • SAN FRANCISCO • KANSAS CITY



"We eat what we choose or must, not according to the National Research Council."[1] But we can *treat* the resulting vitamin deficiencies as we choose, *and* in exact accordance with F.D.A. nutritional standards.

Sharp & Dohme has used exactly 5 times the F.D.A. minimum daily vitamin requirements as the basis of MULSAVITE[2] Capsules Therapeutic Potency Multivitamins:

	MULSAVITE Capsules	F.D.A. Requirements
Vitamin A	20,000 units	4,000 units
Vitamin D	2,000 units	400 units
Thiamine hydrochloride	5 mg.	1 mg.
Riboflavin	10 mg.	2 mg.
Pyridoxine hydrochloride	1 mg.	•
Calcium pantothenate	10 mg.	•
Niacinamide	50 mg.	•
Ascorbic Acid	150 mg.	30 mg.
Mixed tocopherols	10 mg.	•

• No daily requirement established

Jolliffe and Smith stress that "The daily therapeutic dose of vitamins should be at least five times the maintenance requirements. Since they can be given in amounts many times the maintenance requirements without untoward effect, it is better to give too much than too little."[3]

MULSAVITE Capsules are indicated for treatment of concurrent multiple vitamin deficiencies. The dose is one capsule or more daily. Bottles of 30 and 500 easily swallowed capsules. Sharp & Dohme, Philadelphia 1, Pa.

1. Haven Emerson: Journal Lancet, 57:1, 1947. 2. Registered trademark, Sharp & Dohme. 3. M. Clin. North America 27:567, March 1943.

MULSAVITE



Comparative Studies Establish the OUTSTANDING EFFICACY of this Antihistaminic

Quantitative studies to determine the relative efficacy of six leading antihistaminic compounds have demonstrated that Neo-Antergan possesses a considerably greater protective power against histamine than do any of the other antihistaminic drugs tested.*

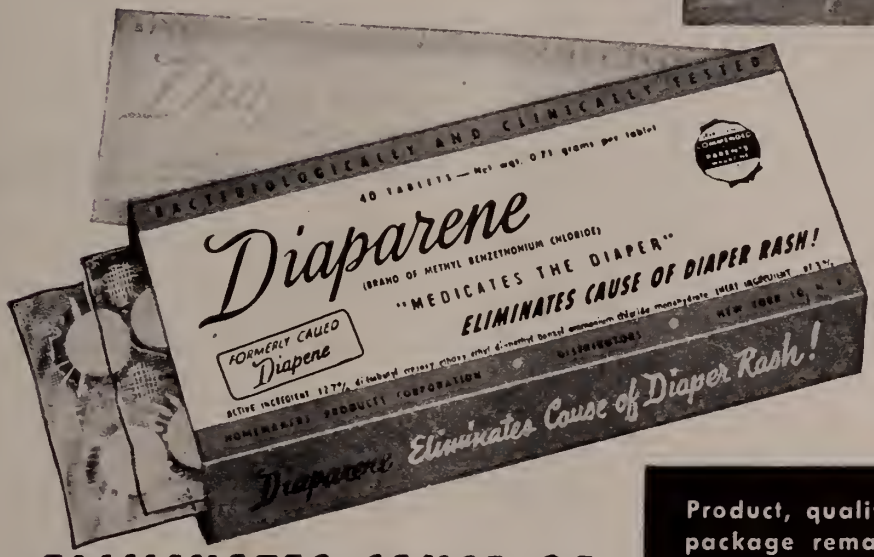
*Friedlaender, A. S., and Friedlaender, S., *Correlation of experimental data with clinical behavior of synthetic antihistaminic drugs. Paper read before Fourth Annual Session, American College of Allergists, New York City, March 12, 1948.*



Your local pharmacy stocks Neo-Antergan in 25-mg. and 50-mg. tablets, supplied in packages of 100 and 1,000.

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

NOW it's spelled Diaparene



ELIMINATES CAUSE OF DIAPER RASH!

Product, quality and package remain the same. DIAPARENE'S new name is easier to *identify*, easier to remember, easier to say.

DIAPARENE is the *first* and *only* non-mercurial, non-volatile diaper-bacteriostat thoroughly tested in laboratory and clinic to prevent formation of urinary ammonia in the urine-wet diaper—the direct cause of *ammonia dermatitis* and ulcerations of the external urinary meatus[1]. . . . Simply prescribe one DIAPARENE tablet dissolved in two quarts of warm water as a final 1:25.000 rinse for six diapers or less. For bactericidal action the concentration may be increased as much as five times (1:5,000)[2]. At your pharmacist in boxes of 20 and 40 tablets.

REFERENCES:

1. Cooke, J. V.: Brennemann Practice of Ped. 4: Chapter 41, 1945.
2. Bensan, R. A. et ol: J. Ped. 31:369-754, 1947.
3. Sullivan, N.: Int'l Congress of Ped., Mt. Sinai Hospitol, New York, 1947.

Division of Pediatric Pharmaceuticals
HOMEMAKERS' PRODUCTS CORP.
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CANADIAN ADDRESS
36-48 Caledonia Road, Toronto, Ontario

MAIL TODAY

HOMEMAKERS' PRODUCTS CORPORATION
380 Second Ave., New York 10, N. Y.

Please send me, without cast, literature and samples of DIAPARENE to eliminate cause of diaper rash *(ammania dermatitis).*

Dr.....

Address.....

City.....Zone.....State.....

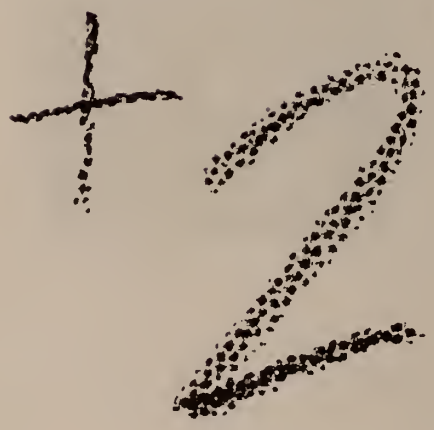
I averoge..... diaper rosh cases weekly.

This penicillin-vasoconstrictor combination provides—



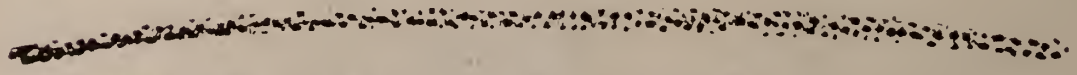
rapid and prolonged shrinkage

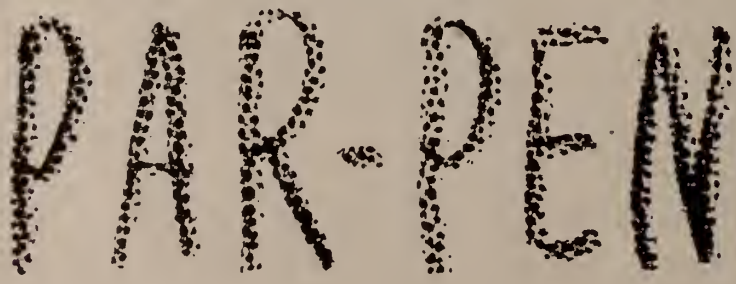
Par-Pen contains 'Paredrine Aqueous'—
one of only two proprietary aqueous
vasoconstrictors favorably noted
in a report issued for the information
of the Mayo Clinic Staff.



potent antibacterial action

Par-Pen contains sodium crystalline
penicillin, now recognized as the
most desirable form of this potent drug.
An important advantage of this new form
of penicillin is its superior stability.
Your patient need not refrigerate Par-Pen.
Even after a week at room temperature,
Par-Pen will contain 500 units of
penicillin per cc.—the accepted
strength for local use.





for
intranasal
use

Smith, Kline & French Laboratories, Philadelphia

middle age + emotional tranquility

In many women, the physical distress of the menopausal syndrome is aggravated by emotional instability. **"Premarin"** *therapy, in the majority of cases, is synonymous with prompt relief of physical discomfort as well as restoration of emotional calm.*

In addition, there is a "plus" in **"Premarin"** *therapy... the gratifying "sense of well-being" so frequently reported following the administration of this naturally occurring, orally active estrogen.*

Flexible dosage regimens to adapt treatment to the particular needs of the patient are made possible with **"Premarin"** *Tablets of 2.5, 1.25, or 0.625 mg., and liquid—0.625 mg. per 4 cc. (one teaspoonful.)*

While sodium estrone sulfate is the principal estrogen in **"Premarin,"** *other equine estrogens... estradiol, equilin, equilenin, hippulin... are probably also present in varying amounts as water soluble conjugates.*



* **Conjugated Estrogens (equine)**

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

"PREMARIN"®

Ayerst

Ayerst, McKenna & Harrison Limited

22 East 40th Street, New York 16, N. Y.

*Estrogenic Substances (water soluble) also known as Conjugated Estrogens (equine)

A STITCH IN TIME



". . . . The prophylactic use of penicillin tends to reduce postoperative inflammation of the oral mucous membrane and the incidence of infection . . . There is less postoperative pain and healing is more rapid." Faier, A.D.: The Prophylactic Use of Penicillin in Dental Surgery. Dental Digest, 153:336, July, 1947.

For either prophylactic or therapeutic purposes, Bristol CRYSTALLINE PENICILLIN G TROCHES with Benzocaine provide an efficient means for controlling intraoral infections due to penicillin-sensitive organisms. Inserted into the buccal sulcus, the troche dissolves slowly, directly bathing all accessible mucous membranes with an effective and prolonged concentration of penicillin. In the presence of painful, inflammatory or traumatic mouth lesions, the local anesthetic effect of benzocaine will be found especially desirable.

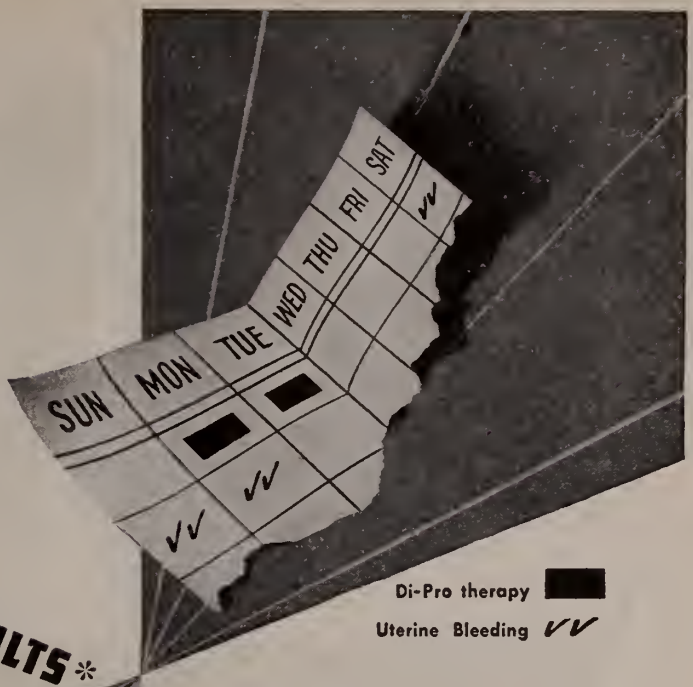
Each pleasantly flavored troche contains 5000 units of Crystalline Sodium Penicillin G, and Benzocaine, 5 milligrams. They are available from your usual source of supply in bottles of 20.

Bristol

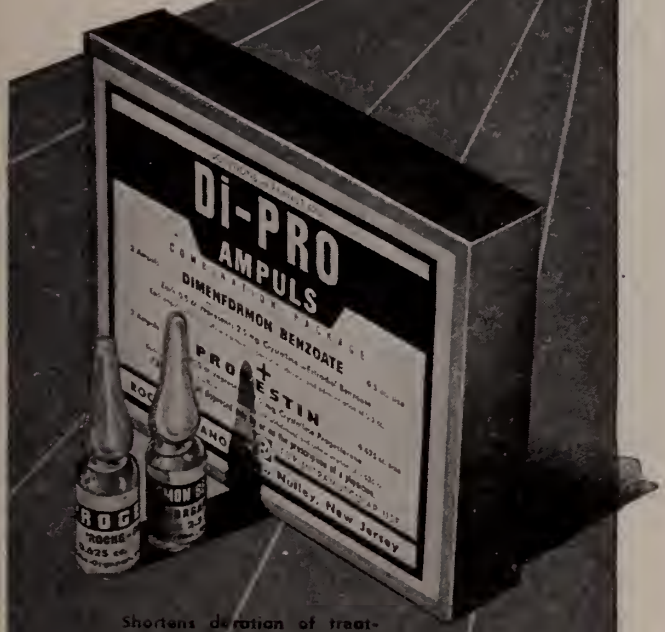
Crystalline Penicillin G Troches

with Benzocaine

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK



MORE RAPID RESULTS* in secondary amenorrhea



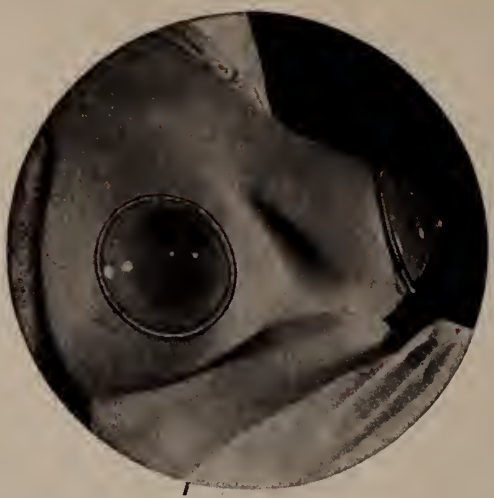
Shortens duration of treatment . . . Offers greater convenience . . . Lowers cost of therapy . . . Minimizes patient's discomfort.

In the treatment of functional secondary amenorrhea of less than two years' duration, the use of DI-PRO ampuls 'Roche-Organon' provides "a rapid method for the induction of bleeding."* Only two injections on two successive days are needed to provoke uterine bleeding in most cases. Each injection consists of 2.5 mg of Dimenformon Benzoate and 12.5 mg of Progestin 'Roche-Organon,' mixed in the same syringe. DI-PRO ampuls are packaged for either one or three courses of treatment.

ROCHE-ORGANON INC.
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DI-PRO *ampuls*
'Roche-Organon'

*S. C. Freed, West. J. Surg., 54: 1, 1946
Trade Marks—DI-PRO and Dimenformon—Reg. U. S. Pat. Off.



Plastishield technic of aseptic breast care . . .



1 • Protects nipple and areola

The new "Plastishield technic" of breast care keeps nipples moist and pliable, thus preventing painful fissuring and soreness.

2 • Encourages breast feeding

This simple, more sterile method of breast care encourages breast feeding by protecting against irritation and eliminating the necessity for ointments and messy medication.

3 • Conveniently applied and sterilized

Plastishields are correctly shaped plastic shields which are easily cleaned and conveniently worn beneath the brassiere or hospital support. They minimize leakage and keep nipples everted.

Plastishield is The Registered Trade Mark of Plastishield, Inc.

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Hypnosis in Minutes...
TONIGHT

Of the frequently prescribed, orally administered barbiturates, 'Seconal Sodium' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly) provides rapid sedation, quick hypnosis, and a short duration of effect.

The hospitalized patient can be assured that the interval between the end of visiting hours and sleep will be reduced. For all patients who want sleep "in a hurry" with no lingering effect the next morning, 'Seconal Sodium' is a barbiturate of choice.

Lilly

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Lilly in Brazil

A 15 x 12 reproduction of this Aaron Bohrod illustration is available upon request.

BRAZIL was discovered and colonized by the Portuguese. Later, besides the Portuguese, came large numbers of other Europeans, notably Italians and Germans. Portuguese, however, is the official and only language of the country. The *Physician's Bulletin,* as well as labels and literature, is printed in Portuguese to serve over 12,000 Brazilian physicians. The first Lilly representative, with headquarters in Rio de Janeiro, began his calls on the medical profession in 1933. In 1945, the Lilly Branch was established, and as soon as suitable facilities are available Lilly products will be manufactured within the country. Here, as elsewhere in the world, Lilly scientists will work closely with physicians, assisting them in the development and clinical evaluation of newer medication. Practical applications of these researches will be made available to the medical profession wherever ethical pharmaceutical and biological products are sold.



The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 4 October, 1948

THE GENERAL PRACTITIONER

During the year that Dr. Harrison H. Shoulders of Nashville was President of the American Medical Association, he was greatly concerned with the status of the general practitioner, and was anxious to see that every consideration possible was given to encourage younger physicians to enter general practice.

During the Atlantic City Session in 1947, Doctor Shoulders made some specific recommendations of interest to all members of the medical profession. He asked the Board of Trustees to appoint a special committee which should

(1) Define the term "general practitioner" or "general physician" on a functional basis;

(2) Determine whether or not there is need for a large increase in the number of medical graduates, and if so, its extent;

(3) Study the present program of medical education and training, both undergraduate and postgraduate, to determine whether or not the content and administration of the program is properly adjusted to the present day needs of the people;

(4) Study the possibility and feasibility of utilizing smaller community hospitals in a program for the training of general practitioners, and the possibility of approving such institutions for such training when a teaching program is properly organized and administered;

(5) Study the means by which communities in need of additional services may be aided;

(6) Study other questions as the committee itself may determine to be necessary in arriving at sound conclusions concerning the entire field of medicine.

(7) Propose a long range program designed to overcome present insufficiencies and to meet future needs.

The committee was appointed promptly, and was composed of Karl A. Meyer, chairman, Paul A. Davis, Reginald Fitz, Winfred B. Harm, Paul B. Magnuson, Walter B. Martin and Stanley R. Truman. After careful consideration of the responsibilities given to them, the committee presented its first report to the House of Delegates at the 1948 annual meeting in Chicago in June.

Its definition of a general practitioner was: "A general practitioner is a legally qualified Doctor of Medicine who does not limit his practice to a particular field of medicine or surgery". The committee thought the matter relative to the need for a large increase in the number of medical graduates was a subject which should be left to the judgment of the A.M.A. Council on Medical Education and Hospitals and the Bureau of Medical Economic Research, as this problem has been given much consideration by these departments, and a considerable amount of data has already been accumulated.

The interest of the approved medical schools in broadening the curriculum to prepare medical

students for general practice was commended by the committee. These schools are being urged to continue to place increasing interest in postgraduate training, and the committee recommends that courses of not less than two years of training be developed to enable the graduate to enter the field of general practice better prepared.

One unusually important recommendation of the committee was that every general hospital be organized to give the general practitioner adequate staff privileges and representation. This, coming at a time when too many general practitioners are denied staff privileges, or are being dismissed as staff members, is welcome news to this group.

The committee recognizes that the smaller community hospitals not directly associated with medical schools, would make excellent training institutions for general practitioners if properly supervised. The committee urges the Council on Medical Education and Hospitals to proceed with the development of such a program.

In regard to the study to aid communities in need of additional services, it was recognized by the committee that this is a function which can best be worked out at the local level. Various agencies within the A.M.A., its component state societies, as well as those of individual states and local communities, have had this matter under consideration, and it is recommended that these activities should be continued.

However, it is the opinion of the committee that more consideration should be given to the trade areas and population needs in planning additional facilities within individual communities. Financial and technical aid are necessary in many communities, and the methods of obtaining such assistance are primarily a community responsibility.

The committee believes that the hospital staff should be the sole deciding body in determining who may practice medicine in the hospital either as a member of the staff, or having hospital privileges. This conclusion resulted primarily from the fact that certifying boards pass only on the ability of a physician to perform work in his specialty.

It was the opinion of the committee that the general practitioner does not show adequate interest in organized medicine — local, state or national — and that he should be urged to participate in all the activities of organized medicine, both scientific and organizational. As for long range planning, the committee believes that would be impossible unless their committee, or another permanent committee was delegated the responsibility of making continued studies of problems as they arise in order that future needs be considered properly and recommendations made.

The committee is to be congratulated upon the fine work it has done. The report shows that the members have devoted considerable time to studying intensively many of the problems of medicine today which pertain to the general practitioner. More consideration has been given the general practitioner during the past two or three years than had been manifest during the past decade, and it is well known to all that what is needed most in the several states in general, is not more specialists, but more general practitioners.

It has been stated repeatedly that a well qualified practitioner should be able successfully and scientifically, to care for not less than 85% of the conditions encountered in his practice, while the other 15% can be referred to specialists. The terms "family physician", "general physician", and "general practitioner" are used interchangeably, yet there is some difference in these designations which we will not endeavor to discuss at this time.

Many people think kindly of the family physician who has been almost a member of the family over a long period of time. He is kind, sympathetic, and never refuses to make a hurried call whenever the family believe his services are needed. This has, in a great measure, been responsible for the classical physician-patient relationship. The present day family physician must endeavor in every way possible to keep up with the times, as he is living in the period of the greatest medical advancement in history.

In keeping with the recommendations of the A.M.A. special committee, the family physician can be a better family physician if he will attend more medical meetings, postgraduate conferences, and take an occasional refresher course for general practitioners. Likewise he will be more useful in his community if he will become interested in his local county medical society, as it is the one medical organization in the community which is looked upon by the citizenry as a whole as the medical society interested in all local affairs pertaining to health.

HOSPITAL CONSTRUCTION IN ILLINOIS DOWNSTATE AREAS

Roland R. Cross, M.D., Director, State Department of Public Health, has released his report on the financial aid which has been approved for the construction of hospitals in the downstate areas. The report shows the amount of money appropriated for grants-in-aid for local public and nonprofit hospital construction projects.

The attached schedule shows the amount of money for each project from federal, state and local sources. The location, bed capacity, estimated cost and other pertinent data likewise are shown in this schedule.

In his desire to do everything possible toward the ultimate aim of providing adequate modern hospital facilities within easy reach of all residents of the state, Doctor Cross has approved applications which conform to the legal requirements. Work has been started on some of these hospital projects, and within the next year, it is hoped that all of them will be under construction and perhaps some ready for occupancy.

With an unusually well developed system of hard roads in Illinois, and with the thousands of miles of all-weather secondary roads, there are but few, if any, communities in the state where citizens cannot reach an approved hospital within a relatively short period of time. When these hospitals which have already been approved are completed and staffed, there will be an increase of hospital bed capacity of more than 1100 beds.

Obviously this is a good start. The hospitals have been located in all sections of the state, and Doctor Cross is to be congratulated on the fine work he has done and the excellent report he has to make on these responsibilities delegated to him by Governor Green.

YOUR DUES HAVE BEEN RAISED

On May 12, 1948 the House of Delegates of the Illinois State Medical Society, in regular session, voted that the annual dues for each member of this state society should be $15.00 per annum for 1949. Of this amount, $10.00 is deposited in the general funds of the society, and $5.00 in The Benevolence Fund. This raise in dues gives the society no extra funds for general

FINANCIAL STATEMENT: HOSPITAL CONSTRUCTION PROJECTS
APPLICABLE TO 1948 AND 1949 FEDERAL AND 65TH GENERAL ASSEMBLY FUNDS ON AUGUST 23, 1948

FUNDS AVAILABLE				SOURCE OF FUNDS State	Federal	Local	TOTAL	Cost Per Bed (Approximately)
1947-48				$2,337,500.00	$2,770,725.00	(For Construc-		
1948-49				2,337,500.00	2,764,357.00	tion Period)		
Total Available				$4,675,000.00	$5,535,082.00	$5,540,654.30	$15,750,736.30	
Total Encumbrances				4,278,401.41	4,862,011.80	5,540,654.30	14,681,067.51	
Unobligated Reserve				396,598.59	673,070.20	——	1,069,668.79	
Project No.	Location	No. Beds	Type of Control					
Ill.-1	Mt. Vernon Gen.	131	NPA	388,000.00	388,000.00	388,000.00	1,164,000.00	$ 8,885.00
2	Anna	50	PUB	221,166.66	221,166.66	237,766.68	680,100.00*	13,200.00
3	Mt. Vernon T.B.	100	STATE	——	446,692.80	910,738.88	1,357,431.68*	13,400.00
4	Fairfield	100	NPA	266,667.00	333,333.00	403,000.00	1,003,000.00*	10,000.00
5	Lawrenceville	50	PUB	146,826.21	200,000.00	270,173.79	617,000.00*	12,000.00
6	Flora	50	PUB	283,267.70	283,267.70	289,267.70	855,803.10*	16,996.00
7	Aledo	50	PUB	262,560.66	262,560.66	262,560.68	787,682.00	15,753.00
8	Carthage	50	NPA	200,000.00	200,000.00	205,000.00	605,000.00*	12,000.00
9	Red Bud	64	NPA	228,879.86	226,341.00	228,879.87	684,100.73	10,564.00
10	Mt. Carmel	50	HOSP. AUTH.	249,933.33	249,933.33	274,933.34	774,800.00*	15,000.00
11	Cairo	90	NPA	500,000.00	519,616.66	539,233.34	1,558,850.00	13,245.00**
12	Metropolis	54	HOSP. AUTH.	247,500.00	247,500.00	247,500.00	742,500.00	13,750.00
13	Carmi	50	NPA	291,666.66	291,666.66	291,666.68	875,000.00	17,500.00
14	Carlinville	50	NPA	291,933.33	291,933.33	291,933.34	875,800.00	17,516.00
15	Jacksonville	140	NPA	700,000.00	700,000.00	700,000.00	2,100,000.00	15,000.00

*The total cost of projects thus marked includes the cost of certain items in which neither the State nor the Federal government participate such as cost of site, landscaping, off-site improvements, etc.

**The $13,245 per bed for Cairo is based upon $1,193,000 of the $1,558,850 which is the estimated cost of the hospital only; the remaining $365,850 is for the construction of a nurses' home.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Hospital Construction and Services
August 24, 1948

activities; it will develop the Benevolence Fund to the place where a trust can be established, and recipients of assistance can be paid from the income.

The activities of the Illinois State Medical Society are diversified, and needless to say, extensive. The list of our committees alone is impressive: The Committee on Medical Service and Public Relations, The Committee on Medical Testimony, The Educational Committee, The Postgraduate Committee, The Committee on Medical History, The Committee on Voluntary Prepayment Plans for Medical and Surgical Care — to name only a few. And your dues to

ORGANIZATION INFORMATION
From Questionnaires Returned By
Forty-five Constituent Medical Associations

ASSOCIATION	YEAR ORGANIZED	MEMBER-SHIP	1948 DUES	EMPLOYEES FULL	EMPLOYEES PART TIME
New York	1807	21,786	$15	54	6
Pennsylvania	1848	10,189	15	20	1
Illinois	1840	9,588	10	8	2
California	1856	9,009	60	9	2
Ohio	1846	7,106	15	11	0
Massachusetts	1781	6,500	25	6	2
Texas	1853	——	20	14	5
New Jersey	1766	4,958	20	9	2
Michigan	1866	4,796	12*	9	3
Indiana	1849	3,617	15	5	0
Missouri	——	3,383	8*	6	1
Minnesota	1853	3,075	20	6	0
Wisconsin	1841	2,936	35	12	0
Iowa	1850	2,377	15	5	2
Connecticut	1792	2,357	20	6	4
North Carolina	1799	2,275	10	2	1
Virginia	1820	2,108	25	2	0
Maryland	1799	2,081	10	5	2
Georgia	1849	2,063	10	1	1
Tennessee	1830	1,958	15	3	1
Washington	1873	1,953	25	3	1
Kentucky	1851	1,779	15	1	3
Louisiana	1903	1,722	25	4	0
Alabama	1847	1,656	20	0	3
Kansas	1859	1,550	15*	4	0
Colorado	1871	1,460	50	10	2
District of Columbia	1817	1,460	30	18	6
Oklahoma	1905	1,400	42	6	0
West Virginia	1867	1,391	15	3	0
Nebraska	——	1,189	15	2	3
Arkansas	1875	1,171	10	1	2
Mississippi	1895	1,000	5	0	1
Rhode Island	1812	772	40	6	0
Utah	1895	558	50	2	0
Arizona	1892	487	50	2	1
North Dakota	1887	——	35	4	1
Vermont	1813	416	35	2	0
Montana	1879	405	25	1	0
Hawaii	1856	382	15	2	1
South Dakota	1882	330	50	6	0
New Mexico	1885	300	20	0	1
Delaware	——	290	25	0	1
Wyoming	1922	196	25	0	1
Nevada	1904	164	15*	0	1
Alaska	1925	43	25	0	0

*SPECIAL ASSESSMENTS: Kansas, $35; Nevada, $50; Missouri, $7; and Michigan, $25.

the general funds of the society have not increased. The additional $5.00 will be paid in to the Benevolence Fund and eventually a trust will be developed. The general counsel of the society will make our plans, and the Finance Committee will act relative to investments.

The Benevolence Fund does not extend charity. The recipients of assistance are former members, and in the future, each physician in Illinois will feel that he has contributed to this fund, and that a minimum income will be available for himself or his widow, or his dependent children should such need arise.

On page 212, we present for consideration, the national picture as depicted in the "News Letter" from the A.M.A. Council on Medical Service dated June 21, 1948.

MEDICAL EXAMINATION PROCEDURE UNDER 1948 SELECTIVE SERVICE ACT

Col. Paul G. Armstrong
State Director, Selective Service System

At the beginning of the operation of the Selective Training and Service Act of 1940, there were appointed one or more physicians as examiners for each Selective Service Local Board.

Registrants who were found *NOT* to be deferrable in Class IV, Class III or Class II, were sent to the Local Board Physician for physical examination, so that all men who were considered for Class I-A, were examined. There was a vastly greater pool of men to be examined in the age group 21 through 35, under this policy. The age group under the Selective Service Act of 1948 that is liable for service, is 19 through 25, with approximately 50% deferred by law because of previous military service or by regulations because of marital status, leaving a comparatively small group to be considered for classification.

The physician attached to the Local Board does *NOT* make physical examinations; he interviews those registrants who have claimed disqualifying defects or diseases under Series XV of the Questionnaire; the doctor then reports his findings to the Local Board, and the Board determines whether or not the registrant will be forwarded to the Armed Forces Induction Station for physical examination.

General Bradley has estimated that 200,000 men may be needed from Selective Service during the first year of the Law's operation. Illinois' portion of that quota would be approximately 12,000 men distributed over 12 months and 217 Local Boards, or about 4 to 5 per month per board, depending on the size of the Board. With only those few who claimed defects to be interviewed by the doctor, no great burden would be placed on any member of the profession.

You are urgently requested to make yourself available to assist in this vital National Defense program.

"I WILL ACCEPT THE RESPONSIBILITY PLACED UPON ME"*

"Always, I suppose, to all persons who are so honored, the acknowledgment of an honor becomes a very difficult procedure.

I am impressed with the responsibilities which you have placed on me. Personally, I offer to the House my deepest thanks and gratitude for thus honoring me. I feel no elation. I should, I suppose, but any spark of elation is overcome by a sense of responsibility.

I have been preceded in office, for the last two or three years particularly, by men who have given yeoman service to medicine. We have before us a temporary cessation of the efforts to abridge the freedom of American medicine. We have won some preliminary skirmishes but, make no mistake, we are not through with this fight. It is a fight that is much more than the fight for the freedom of American medicine. It is a fight for the preservation of American democracy and the American way of life. We have knowledge that there are other attacks in the offing, and I know that the Board of Trustees and your other officers are taking the necessary steps to combat them.

But the battle is going to come a little later, and as the termites that have been boring from within against our democratic way of life become a little more conscious of a losing battle, we shall find that the attacks will become a little more subtle, if that could be, and a little more vigorous.

The opportunity of this House is particularly great now, for you may be able and should be able to arouse in all county medical societies a

*The text of the address of Dr. Ernest E. Irons, accepting the office of President-elect of the American Medical Association, Chicago, Ill., June 24, 1948.

will to get out and fight locally, and that has not been the case up to date. I say that not in criticism but merely as a statement of fact.

As we all go back to our daily routine, I hope that every one of us may begin, if he has not already begun, an effort to arouse the profession in the county societies and then at the state levels. If we do that, we have 130,000 doctors who can swing anything and bring the public to know the problems that they are facing and the efforts that they must make if they are to maintain their individual freedom and the American way of life.

Again, I thank you for this signal honor which I feel very deeply. I *hope* I have expressed in some small way my thanks to all of you."

FIRST NATIONAL MEDICAL PUBLIC RELATIONS CONFERENCE SCHEDULED

A national medical public relations conference, first of its kind, which will tackle six common objectives facing the medical profession today is to be held in St. Louis on November 27. Dr. George F. Lull, secretary-manager of the American Medical Association announced the meeting today which his office will sponsor.

"Shooting at Common Targets in Medical Public Relations" is the theme of the conference, to which will be invited public relations directors, executive secretaries charged with public relations duties and public relations committee chairmen from each of the forty-eight state medical societies.

Featured for luncheon and dinner talks will be noted and qualified speakers on the following topics: "The Public Speaks on Health", "What Public Relations Did for Us" and "Yes, the Profession Needs PR."

At the workshop session which will be run in the afternoon from two to five o'clock, carefully-selected discussion leaders from the state societies will grapple with these six major social issues facing the medical profession: selling the need of public relations to state medical society members, encouraging wider use of medical pre-payment plans, setting up workable systems for handling night calls, the rebate problem, developing good-will with labor, farm, industrial and co-op groups, and cooperating with health agencies.

The conference will immediately precede the annual secretaries-editors meeting, which is being held in conjunction with the annual Interim Session of the American Medical Association, November 28 to December 3.

About 100 representatives of state societies are expected to attend the sessions in St. Louis.

STATISTICIANS FIND RELATIVELY LOW MORTALITY AMONG SPECIALISTS

The mortality rate of physicians who specialize is 30 per cent lower than that of general practitioners, according to a report by Louis I. Dublin, Ph.D., and Mortimer Spiegelman which appears in the August 21 issue of the Journal of the American Medical Association.

The two statisticians are from the Metropolitan Life Insurance Company, New York City. Their report is based upon data from the American Medical Directory.

Commenting upon the lower mortality of specialists, they say that the rate "may arise from the self selection of the healthier physicians to continue their studies, from higher income levels, from more favorable conditions of work, and from better opportunities for better medical care.

"The rate of mortality from cancer among general surgeons is well below the record for any other specialty and also for nonspecialists. Their advantage in this regard may be a consequence of their training in early recognition of the condition and of their knowledge of the benefit of early treatment.

"On the other hand," they say, "roentgenologists, radiologists, and dermatologists have a high rate of mortality from cancer and leukemia, far above that for nonspecialists. This situation among these specialties suggests strongly the effect of their exposure to dangerous radiations."

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Emmet B. Bay, Edwin F. Baker, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Ford K. Hick, Edwin F. Hirsch, May McDonald Milligan, Marie Wessels, Walter M. Whitaker, Holland Williamson.



The Pathologist In Group and Hospital Practice

The practice of pathology as a specialty stems from the fact that this field of specialization deals with the cause of diseases and the morphologic changes produced in the tissues. Pathology in the medical curriculum belongs with the basic sciences and because it is fundamental in medical practice the functions of the pathologist are essential in almost every field of specialized medicine. This need of the pathologist in medical practice has arisen through the development of diagnostic methods carried out entirely or in part by laboratory personnel under his supervision and through the more prevalent demand of tissue examinations which require his skill and experience for interpretation and diagnosis. Many physicians in years past chose pathology because of the satisfying interest in this field, and much of their time was spent as teachers of pathology in schools of medicine. Others, not concerned with academic interests, served as part-time pathologists to hospitals as a medium for subsistance while engaged in developing a clinical practice. With few exceptions, this plan resulted in more emphasis and time being spent in promoting the clinical practice and less effort in developing skill in pathology, if not entirely abnegating this field. Some survived as pathologists, confining their interests entirely to this specialty, improving their ability by study and experience and living to see the time when the demand by hospitals for pathologists had increased greatly, perhaps exceeded the supply, and when, because of the larger salaries offered, hospital positions are in competition with teaching appointments in medical schools.

Although any well-trained physician has the potential capacity to become a successful pathologist, those engaged in this field of specialization profit greatly from a comprehensive premedical training in biology and chemistry, subjects which emphasize technic, observation, understanding and correlation of biological data. Admission to the examinations for certification in Pathology is granted by the Board of Examiners after three years of specialized training under an accredited pathologist and a year of practice in the specialty. Thus equipped to direct a laboratory, the pathologist integrates the services of his specialty with those of other specialists or general practioners with whom he is associated. Here are tested his

professional qualifications, personal characteristics and ability to work in groups. On his part he becomes acquainted with similar qualities of his associates and doubtless has learned some of the requirements of these relationships during his training program. Tactfulness, honesty, tolerance in personal difference, and frankness in discussions are among the elements necessary for effective team work in such group relations. Perhaps the greatest stress occurs in matters involving honesty and fair dealings.

Because the pathologist can demonstrate specific and characteristic lesions in many of the tissues submitted for examination, precision in diagnosis in his field can approach a high level and at a plane of accuracy admittedly above that obtainable by physical examination. This comment does not intend to arouse an argument on the advantages in either field of specialization, but simply frames the relative position of each of the specialties in this respect. It gives neither to the pathologist the right of judgment over the clinician, or to the clinician the attitude of belittlement of the pathologist when a disease is disclosed in tissues which the clinician had not suspected. Discussion by all concerned of the evidence disclosed by the tissue examination is the proper approach. This attitude is especially important in necropsies. These examinations serve their highest function when the pathologist and the clinician work together, the pathologist serving as a demonstrator for the clinician rather than a ruthless judge. This does not mean any timidity about disclosing faulty practice of treatment and therapy, because the necropsy is a searching experience for all. Respect for the pathologist grows with his skill in making the postmortem examinations and his ability to correlate for the clinician the symptoms of his patient with the conditions disclosed in the tissues. No pathologist in serving his function as impartial arbitrator escapes the experience of sharing a necropsy with a clinician where pathological changes were encountered which in retrospect established faulty diagnosis or treatment. This is a real test of the quality of a physician's character. Can he accept a hard lesson with equanimity and determination to profit; or does he stubbornly resolve not to expose himself to a similar experience. The frankness with which clinicians discuss the results of these postmortem examinations reveals an honesty and sincerity of purpose which dispels any suspicion of fear about the disclosures of the postmortem examination. The more recent graduates of medical schools and those having finished residency appointments have been exposed to this form of medical education and postgraduate teaching.

The supervision of the clinical laboratory services is a responsibility of the pathologist. In these functions he wins the confidence of his associates through developing a high quality of service in the various departments, being alert to new methods or revisions of examinations, and expediting procedures so that the results are reported promptly. Nearly all large and many small hospitals have installed blood bank facilities. These usually are given to the pathologist for organization and development. Clinical pathological conferences and other educational facilities for the medical staff are important adjuncts in hospital activities. The pathologist has much responsibility in the programs of these conferences. His ability to present and discuss the lesions in the autopsy or surgical material determine in a large measure the interest and attendance of these meetings. The value of visual education has been demonstrated in many fields of study. At conferences for large groups, various projectors such as for opaque objects, slide preparations of tissues, and lantern slides in black and white and Kodachrome greatly facilitate the exposition of the subject material. The pathologist should be provided with equipment for these purposes. Where circumstances permit, Kodrachrome photography (lantern slides) add much to the expositions. These become available later for use by the pathologist and staff physicians. Kodachrome slides obtained in this way gradually assemble into valuable collections for teaching purposes.

The pathologist, thus, can render signficant service in his specialty in group and hospital practice and also may contribute much to stimulating the educational activities of the medical staff. He should be recognized at the same levels of staff appointment as the other specialists, and neither he nor the laboratory organization under his direction should be exploited financially.—E. F. H.

MEDICO-LEGAL BRIEFS



Possible Liability in Operations To Produce Sterility

Although the law is now well settled in many jurisdictions that therapeutic abortion may legally be performed in a proper case, the status of operations to produce sterility is by no means clear or settled. The question of possible civil or criminal liability in such matters is apparently increasing in importance to physicians and hospitals alike.

While numerous states have adopted widely dissimilar sterilization statutes, many of the larger states, Illinois among them, have thus far refrained from legislating on the subject. Those states which have prohibited or restricted the performance of operations to produce sterility have, for the most part, done so upon the theory that such operations are, except in certain instances, contrary to public policy. Whether the courts of Illinois would so hold is still a matter of conjecture, since the question has not been adjudicated. We can, however, in the light of the history and trend of the lawmaking, legislative and judicial, on the subject, make some reasonably enlightened guesses as to what our courts would probably hold.

The question of liability divides itself into two parts: (a) does the performance of such an operation constitute a violation of criminal law; and (b) is such an operation a tort giving the patient or his family a right to recover damages from the physician or hospital?

On the question of criminal responsibility, it seems entirely safe to assume that surgery to produce sterility for sound reasons of health would not now be considered a crime. Illinois has no statute expressly rendering such an operation illegal, and there seems to be no reason to assume that our courts would hold the same to be violative of any existing criminal statute, or criminal apart from the statute law. This is probably true whether the particular operation were therapeutic, eugenic or contraceptive, although it is at least conceivable that a court might deem a contraceptive sterilization contrary to public policy and the other types not.

The problem of civil liability for damages can be amply dealt with by the taking of proper consents from the necessary persons prior to the operation. In order that physician and hospital

may be adequately protected, it is extremely important that consents should be sufficiently broad and detailed, and that all necessary persons be required to sign them. In general, it would be wise to take the same precautions as are routinely taken prior to the perfomance of therapeutic abortion. Every effort should be made to ascertain whether the patient is married, even though the patient may profess to be single. The non-consenting spouse of a person sterilized would unquestionably have a cause of action unless all reasonable effort had failed to disclose the patient to be married. Should there be any doubt that an unmarried patient is of legal age, good practice would require that his or her parents join in the consent.

The consent form itself should be detailed and explicit. It should specify the exact type of surgery to be performed, and should also set forth — for the information of the persons signing the consent — the material medical findings rendering the operation necessary. It would also be wise to include a statement, where appropiate, that the results of the operation are not guaranteed. In at least one case, a physician was sued, though unsuccessfully, on the theory of a breach of warranty where a pregnancy occurred after such an operation. It would also be wise to have consultation in all such cases, to bolster the judgment of the attending physician as to the need for or advisability of such an operation.

In summary: On the basis of present authorities, it seems safe for physicians and hospitals to assume that a sterilization operation predicated upon reasonable medical grounds is not an unlawful act in Illinois. While the same might ultimately prove to be the case as to contraceptive sterilizations, there is no logical basis for so assuming at the present time. The other phase of the problem — that of civil liability — can be satisfactorily provided for by the taking of proper consents.

PROPHET WITHOUT HONOR UNLESS A BANDIT

An announcement that a couple of top-flight movie stars expect to pay a Hollywood physician $20,000 for delivering their baby got quite a play in the newspapers recently and provoked the usual smart-alec editorials in some sheets about doctors' charges, ethics, and the like. Imagine weeping over anything that happens in Hollywood!

About the same time we came across a brief paragraph on the back page of a certain small Ohio newspaper announcing that some new rates had been agreed upon by the doctors of the county—a really rural community. Here they are: Office call, $2.00; house call, $3.00; long-distance house call, $3.00 plus 50 cents per mile one way; normal o. b., $50.00; premarital examination and certificate, $10.00; X-ray, fractures, dislocations, per Industrial Commission schedule. Imagine in 1948 A. D.!

That announcement didn't get much publicity. Obviously, it wasn't dignified by an editorial. Too bad!

Nobody gives a hang how often the editorial writers and columnists tee off on the physician who gouges patients, although he's probably beyond saving. But, it would be comforting to see more nice words written about some of the mighty nice things so many physicians do all the time for their patients and the community, so the folks will realize that in the end only a few members of the medical profession can trace their ancestry back to Jesse James.

The Ohio State Medical Journal, Sept. 1948.

STATE DEPARTMENT OF PUBLIC HEALTH

The Course of the Maternal Death Rate In Illinois

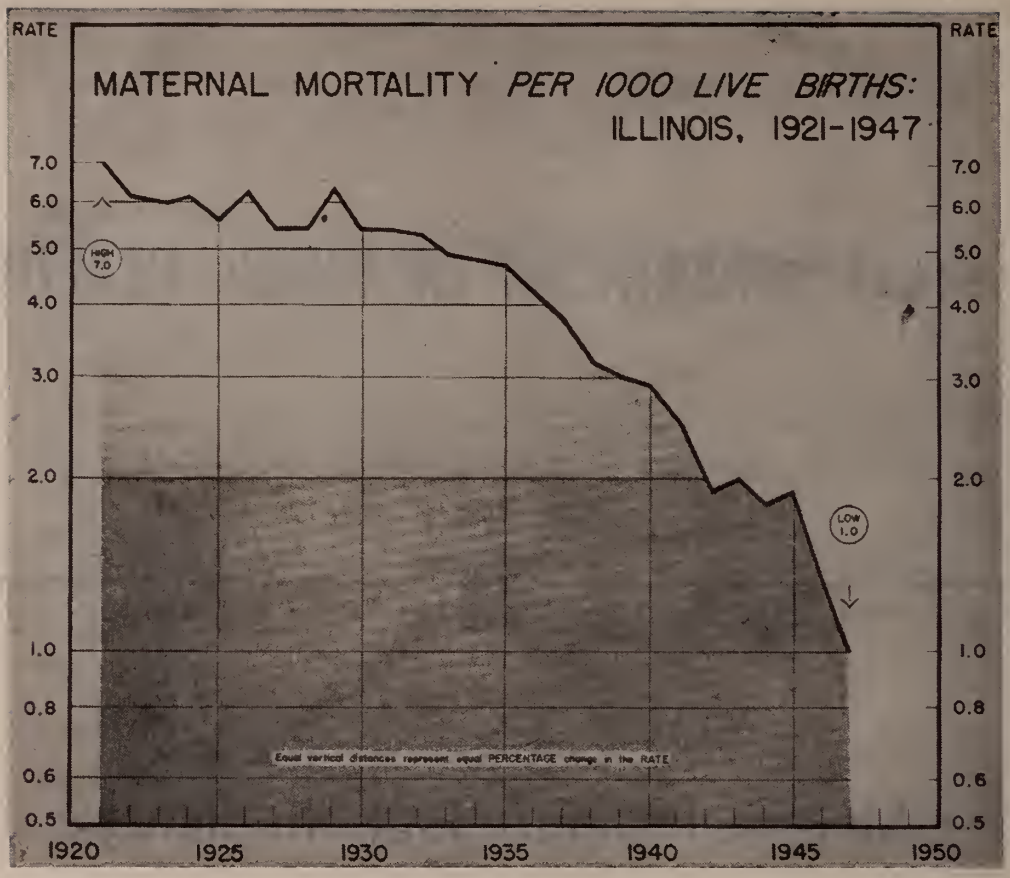
The highest birth rate and, at the same time, the lowest maternal death rate in the history of Illinois occurred in 1947. There were 192,248 live births, a rate of 23.4 per 1,000 population. Ninety-four per cent of the live births (180,364) occurred in hospitals. During 1947 there was a total of 200 maternal deaths, a rate of 1.04 per 1,000 live births. In the group of hospital confinements, there were 176 maternal deaths, a rate of 0.98 per 1,000 live births. The non-hospital confinements totaled 11,884, with 24 maternal deaths, for a rate of 2.02 per 1,000 live births.

The graph illustrates the decline of maternal deaths in Illinois during the 27 year period, 1921-1947. These data are presented in arithlog form in order to portray not only the numerical decrease in rate, but also the relative change from year to year. Equal vertical distances represent equal percentage change in the rate. From the graph, one can read that the maternal mortality rate in 1921 was 7 per 1,000 live births. Had circumstances then existing continued to prevail in 1947, there would have been 1,346 maternal deaths last year, instead of the 200 which were recorded. The saving of these 1,146 lives, and the decrease in the risk of death associated with gestation, is a remarkable attainment which, no doubt, seemed an impracticable goal 27 years ago. From the graph it is apparent that the rate has been cut in half since 1943 and that most of this drop occurred in the period 1945-1947.

Whether or not a similar per cent decline can be expected to occur in the next two-to-five year period depends on:

1. Continuance of the forces which have figured in the prevention of deaths, and
2. Removal of the factors which continue to cause maternal deaths.

Before it can be decided whether or not the favorable forces are likely to continue to operate as they have in the past, it is essential to determine the nature of these forces. Since many of them are broad phenomena and none has been subject to controlled experiment, attempts to define them are likely to be incomplete and subject to bias. But, from a physician's point of view,



certain to be included among the forces which prevent maternal deaths are improved socio-economic circumstances of the people, increased literacy, augmented public health education, improved medical education, the use of blood-products and the newer antibiotics, better distribution of health service personnel, greatly increased use of hospitals for obstetric care and the improvement in hospital facilities and maternity routines. If these be the important factors, we may expect most of them to continue in their influence. Chances are that better distribution of hospitals, brought about through the Hospital Survey and Construction Act will bring improved facilities and more opportunities for health service and health education than existed heretofore in many sections of Illinois. The increase in local health units promises larger staffs of public health nurses to find the early prenatal cases and to encourage them in good maternal hygiene and the carrying out of physicians' orders. Perhaps it is too much to expect that there will be a new set of miracle-drugs, but there are likely to be consolidated gains in the application of available knowledge of biologics, nutrition, and clinical technics.

With regard to the second aspect of the problem — that of the factors which continue to be the cause of maternal deaths — the State Department of Public Health is gratified to report that a concerted effort is under way. Under the joint auspices of this Department and the Maternal Welfare Committee of the Illinois State Medical Society, a study of maternal deaths began in January 1948. The study involves analysis of maternal deaths which occur in hospitals of the State, excluding the City of Chicago, where such analysis has been going on since 1938. The investigation is made by the State Health Department. The physician assigned to the project is a Consultant in Maternity of the Division of Maternal and Child Health. The Department is very fortunate in having as the Consultant to inaugurate this program, Charles Newberger, M.D., a physician with many years of practice, most of which were limited to ob-

stetrics, with 32 years teaching in the Department of Obstetrics at the University of Illinois College of Medicine, and with specialist certification by the American Board of Obstetrics and Gynecology. The investigation starts with the reporting of the death by the hospital administrator. Then a visit is made to the hospital for thorough study of the patient's record, and for interviews with the attending physician, superintendent, obstetric supervisor, record librarian, or other personnel who can contribute to the total body of information concerning the case. A written report of the data so obtained is prepared under a maternal-death-study case number, without mention of the name of the patient, physician or hospital involved. Copies of this report are mimeographed and sent to each member of the Maternal Welfare Committee. The Committee confers periodically to discuss the case reports, determine preventability, and assign responsibility.

In the first six months of 1948, there have been studies of 43 deaths associated with gestation. These called for visits to 38 hospitals in 27 counties, and interviews with 134 individuals, of whom 48 were physicians. Of the 43 deaths, 36 were classified as maternal in origin, and 7 as non-maternal. The assigned causes in the 36 obstetric deaths were as follows:

Hemorrhage		17
antepartum	5	
intrapartum	1	
postpartum	4	
due to abortion	1	
due to ectopic	6	
Toxemia		6
eclampsia	5	
nephritis	1	
Infection		6
puerperal	2	
septic abortion	4	
Embolism		3
all followed operative procedures; 2 after cesarean section, and 1 for a wrongly diagnosed ectopic pregnancy.		
Ileus (after a cesarean section)		1
Aspiration pneumonia		1
Puerperal psychosis		1
Acute heart failure (?)		1

The assigned primary cause of death in the seven non-obstetric cases were as follows:

Rheumatic heart disease	2
Diabetic coma	1
Encephalitis	1
Tuberculosis meningitis	1
Ruptured duodenal ulcer	1
Sepsis (following perforation of the uterus in an attempt at self-induced abortion, in a patient who in error believed herself pregnant.)	1

Twenty-three mothers were delivered before death occurred. The nature of the deliveries was as follows:

Spontaneous deliveries		9
Operative deliveries		14
cesarean section	6	
forceps	5	
low	3	
mid	1	
high	1	
breech extraction	1	
version and extraction	1	
ovum forceps	1	

To these 23 mothers, 25 infants were born: 23 infants to mothers who died after delivery, and twins by postmortem section in an eclamptic patient. Of these 25 infants, 16 were born alive, and 9 were stillborn. Of the 16 living infants, 2 died: one previable premature who lived 5 minutes and one premature who lived 20 hours.

In addition to deaths from abortions, ectopic pregnancy, and perforation of a hollow viscus following attempts at abortion when no pregnancy existed, there were 9 mothers who died undelivered: four from eclampsia, two from heart conditions, and one each from embolism, diabetic coma, and tuberculous meningitis.

In the course of the study, considerable additional material has been gathered, all of informative character, and of potential educational value, dealing with marital status, race, age, gravidity, and months of gestation, type of community of patient's residence, the completeness of facilities in the hospital where death occurred, medical records, and autopsies. In the instances of the seven deaths which upon study were determined as non-maternal, the investigation has been responsible for changes in the official coding of cause of death in the State and National Vital Statistics Offices. This kind of change will in

TABLE 1
MATERNAL DEATH RATES BY REGION:
ILLINOIS 1947

Region	Number of Live Births	Maternal Deaths	
		Number	Rate Per 1000 Live Births
Illinois Total	192,248	200	1.04
Region 1—Chicago Metropolitan Area Cook, DuPage, Kane, Lake, Will	114,011	101	0.89
Region 2—Northern Area Boone, Bureau, Carroll, DeKalb, Grundy, Henry, JoDaviess, Kankakee, Kendall, LaSalle, Lee, McHenry, Ogle, Putnam, Rock Island, Stephenson, Whiteside, Winnebago	19,940	20	1.00
Region 3—Peoria Metropolitan Area Peoria, Tazewell	6,226	7	1.12
Region 4—Central Area Adams, Brown, Calhoun, Cass, Champaign, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Fulton, Greene, Hancock, Henderson, Iroquois, Jersey, Knox, Livingston, Logan, McDonough, McLean, Macon, Macoupin, Marshall, Mason, Menard, Mercer, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott, Shelby, Stark, Vermilion, Warren, Woodford	28,993	28	0.97
Region 5—East St. Louis Metropolitan Area Madison, St. Clair	8,680	12	1.38
Region 6—Southern Area Alexander, Bond, Clay, Clinton, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White, Williamson	14,398	32	2.22

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Hospital Construction and Services
August 9, 1948

TABLE 2
MATERNAL DEATH RATES BASED ON 1000 LIVE BIRTHS IN SELECTED HOSPITALS BY REGION, 5 YEAR EXPERIENCE: ILLINOIS 1943 THRU 1947

Selected Hospitals by Region	Live Births	Maternal Deaths	
		Number	Rate Per 1000 Live Births
Region 1—Chicago Metropolitan Area			
Hospital A	18,341	5	0.27
Hospital B	10,624	10	0.94
Hospital C	7,067	13	1.84
Hospital D	6,615	1	0.15
Hospital E	8,786	11	1.25
Hospital F	6,929	2	0.29
Hospital G	13,748	18	1.31
Region 3—Peoria Metropolitan Area			
Hospital H	10,863	12	1.10
Region 5—East St. Louis Metropolitan Area			
Hospital I	5,080	10	1.97
Total all 6 Regions, all Hospitals	721,231	1106	1.53

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Hospital Construction and Services
August 13, 1948

itself have the effect of lowering the maternal death rate for the year 1948, provided that the other circumstances remain relatively constant.

The Maternal Welfare Committee, in their review of the data, has passed judgment on the preventability and responsibility for these losses, as is the custom in such reviews in Chicago, Philadelphia, Baltimore, New York and the several states where such investigations are currently being made. The plan is to have all this information, as well as abstracts of the more instructive cases, available for presentation before medical groups in the State, and for publication in the Journal.

The State Health Department expects, however, that the fruits of the maternal death study will go beyond the publication of scientific treatises and the presentation of talks to special medical groups. The Department believes that there might be revealed sufficient common denominators still operating to the detriment of our mothers that periodic generalizations can be formulated and can be presented to the medical, hospital administrative, and lay public in order to stimulate corrective measures. At the present early period of the study, review of the breakdown on the 36 maternal deaths referred to above, discloses that 17, or 47 per cent, were attributed to hemorrhage. How many of these cases of hemorrhage are due to conditions which through individual or group action can be ameliorated? Did these deaths occur under circumstances where a more adequate supply of blood and blood derivatives could have sustained the patient until the hemorrhage was stopped? Why, in these times, need a State like Illinois experience five deaths attributed to eclampsia? Is our pattern of prenatal care and education in the hygiene of pregnancy all that it should be? We expect that answers to questions like the above will, in time, come out of this study and that a practicable course of action will be brought to sharp focus.

That the State has not reached an irreducible minimum of maternal deaths is evident from study of Tables 1 and 2 which show the variation in experience in selected regions and selected hospitals of the State. Some of the differences in maternal death rates portrayed in these two tables are within the limits of chance variation, but others are sufficiently striking to encourage and justify painstaking search for the truths that underlie these variations in experience in our State.

NEW FORM OF PENICILLIN EFFECTIVE FOR 24 HOURS

CHICAGO — A comparatively new form of penicillin, "intracillin," produces "an effective blood penicillin level" for 16 to 24 hours, according to five researchers from the Division of Pharmacology and Chemotherapy, Warner Institute for Therapeutic Research, and the Medical Department, William R. Warner & Co., Inc., New York City.

Writing in the September 11 issue of The Journal of the American Medical Association, the researchers — N. Ercoli, M.D.; W. C. Hueper, M.D.; L. Landis, M.S.; B. S. Schwartz, M.A.; and F. J. Queally, M.D., say that intracillin is a preparation of potassium penicillin, oil, and adrenalin.

Tests on 25 volunteers show that no significant increase in blood pressure can be attributed to intracillan. Blood pressures were taken at intervals up to 21 hours after intracillin was injected. The preparation can be given with ordinary syringes and needles.

Clinical study has confirmed the therapeutic value of this type of penicillin. In studies made at the New York City Department of Health, a single injection of intracillin cured 97 out of 100 male patients with gonorrhea. The three patients who did not respond to the first injection, were promptly cured with a second injection, the article says.

CORRESPONDENCE



ORGANIZATION OF AUXILIARIES IN ILLINOIS

Each County branch of the Illinois Medical Society has the privilege of having an auxiliary composed of wives of members of the State Society. We, as members of the Woman's Auxiliary to the Illinois State Medical Society, hope during the year to make eligible women cognizant of their opportunity to join with us in promoting the aims and ideals of our great organization. We feel that with the help of members of the Illinois Medical Society in familiarizing their wives with the work and purpose of the Auxiliary that we will make progress; eventually having an auxiliary organized in every county in our state where one is feasible.

At the present time our nearly 1300 members are represented in twenty county organizations and in thirteen other counties that have members-at-large. Last year while no new counties were organized we gained 206 new members throughout the State. The number of members-at-large is steadily increasing which is one of our strongest links. A chairman of the members-at-large keeps them informed of all important auxiliary matters.

There are ninety County Medical Societies in Illinois, so our Auxiliary Organization work is only one-third done. The reassuring angle is that though we move slowly we always more forward.

The organization committee is composed of the councilors from the thirteen districts of the State Auxiliary. Each councilor works in her district to further the interests of the Auxiliary. Now let every member do her part, too, in making this another year of growth for our very worth while organization for doctors' wives only.

Mrs. E. M. Egan,
Organization Chairman

ILLINOIS NATIONAL GUARD MEDICAL DEPARTMENT LETTER

The new National Guard is more than a hobby with pay; it penetrates into the very hearts of the thousands of interested persons who make up its various units. This was thoroughly demonstrated during this past month when eight Medical and three Dental Officers adequately handled the medical needs of some 6,000 National Guard troops of the 44th Infantry Division and attached troops in the hot and dusty fields of Camp Ellis, Illinois. These Medical and Dental Officers went about the business of sick call, sanitary inspections, evacuation of patients and administrative details with such vigorous energy that no epidemics of diarrhea or contagious diseases took place and only a few medical and surgical cases had to be evacuated to a nearby hospital. The same feat was repeated in the

various other summer encampments of the National Guard. Shouldering a tremendous responsibility, National Guard physicians and dentists throughout the state spent a vacation with pay, working like troopers and having a wonderful time doing so.

National Guard weekly drill pay consists of 1/30th of a months basic pay including longevity credit. A Captain would draw, for one two-hour weekly drill period $7.67, plus what longevity pay he has accrued. Summer camp pay consists of regular basic pay, plus longevity and each officer receives subsistance and rental allowance according to the rank held by the individual.

Physicians and dentists up to the age of 26, who were members of the Guard prior to the enactment of the present peace time Selective Service Act are exempt from the draft. This same advantage applies to all enlisted men of draft age who were Guard members before the President signed the law. Thus, many young doctors are able to continue in the medical practice or take special training along with their army duty in the Guard. Many medical and dental students are therefore allowed to pursue the same course of instruction without interruption for service under the present draft bill.

National Guard Medical Officers can serve one grade higher than the grade set up by the table of organization. Thus, a doctor, separated from the service as a Lieutenant Colonel, can serve in grade as a regimental surgeon, which normally calls for the rank of Major. In the same manner Majors can serve in the positions calling for Captains without taking the reduction in grade.

Nondisability Retirement is available to members of all Civilian Components of the Armed Forces. The National Guard training schedule allows each member to accumulate enough points per year to qualify for this retirement. It is next to impossible in certain reserve components to earn enough points according to the present schedule, to benefit by the provisions of the Retirement Act. Following is a summary of the law as pertains to the above-mentioned point system for nondisability retirement.

1. Retirement pay granted at the age of sixty.

2. Retirement pay granted to any member of the various civilian components of the Army, Air Force, Navy, Marine Corps, who has served twenty or more years in any or all of the above services.

3. Each member must complete a year of satisfactory Federal Service for each year of pay.

4. A year of satisfactory Federal Service is a year wherein a person is credited with a minimum of fifty points.

5. One point is credited for each day of active Federal Service.

6. One point is credited for each drill period or periods of equivalent instruction.

7. Fifteen points are credited for membership in any reserve component for each year of Federal Service other than active federal duty.

8. No person can accumulate more than sixty points a year earned under the provisions of paragraph 6, and 7, above.

9. Each year of service, as a member of a reserve component prior to the enactment of the law shall be deemed to have completed a year of satisfactory Federal Service.

10. Retired pay is paid at an annual rate equal to 2½% of the active duty annual base and longevity pay.

11. Retired pay is based on a year of three hundred and sixty days.

12. Retired pay is paid on the basis of the highest rank held in the entire span of service of the person concerned.

13. No one may receive retired pay to exceed 75% of the normal active duty pay for the grade concerned.

14. A National Guardsman earns at least seventy-five points each year during regular drill and summer field training and does so in the following manner: Forty-eight drill periods equal forty-eight points. Membership in the Guard equals fifteen points making a total of sixty-three points, however, he can use only sixty of these points because summer camp in an active duty capacity adds fifteen more points to the above total, making a grand total of seventy-five points thus meeting the requirements set forth in the law.

15. In the Officers Reserve Corps, unless the person is a member of a class A unit there is not enough regular drill instruction or camp periods to allow an annual accumulation of the required fifty points.

The average Officers Reserve Corps member earns a total of twenty-seven points in a year of normal instruction, i.e., twelve points are earned from the monthly instructional periods and the additional fifteen points are gained from being a member of the civilian component. In order to earn the additional twenty-three points during the year the member will have to go on a tour of active duty for more than three weeks each year.

Membership in the New National Guard therefore provides a retirement pay of about $100.00 a month for rank of Colonel, compared to a civilian

insurance policy of $15,000, or an income of $18,000 in the span of fifteen years after retirement if the person lives to be seventy-five years of age. Thus the National Guard affords Medical and Dental Officers excellent advantages from the standpoint of national and professional security.

The Committee: Lt. Col. Arthur E. Diggs, Lt. Col. John R. Tambone, Lt. Col. E. W. Telford, Lt. Col. Ivar E. Dolph, Major Frank Lock.

PAYMENT UNDER THE EMIC PROGRAM

To the Editor:

The U. S. Children's Bureau has again pointed out that funds for payment of maternity care under the EMIC Program are available only for care provided to eligible women where

a) such care was provided (by the physician, nurse or hospital) before June 1, 1948 and
b) the authorization for the provision of such care was issued before July 1, 1948.

Care during the first year of life for eligible infants must be completed before April 20 of next year, 1949 and must be authorized before May 20, 1949.

It is important that outstanding maternity bills be submitted before December 1, 1948 for payment through the Division of Maternal and Child Health, Illinois Department of Public Health.

Very truly yours
Donaldson F. Rawlings, M. D., Chief
Division of Maternal and Child Health

PRIZES FOR RESEARCH IN UROLOGY

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel in Los Angeles, May 16-19, 1949.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis 3, Tennessee. Essays must be in his hands before February 15, 1949.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Madison, Wisconsin, May 26th, 27th, and 28th, 1949, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than March 15th, 1949. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

TESTS FOR OPHTHALMOLOGISTS

Candidates for the certificate of the American Board of Ophthalmology are accepted for examination on the evidence of a Written Qualifying Test. These Tests are held annually in various parts of the United States.

Registration is already closed for the next Test to be given in January 1949.

Applications are now being accepted for the 1950 Written Test. They will be considered in order of receipt until the quota is filled.

PRACTICAL EXAMINATIONS FOR ACCEPTABLE CANDIDATES 1949

San Francisco March 21-24
New York June 11-15
St. Louis October 15-19
Boston December

ORIGINAL ARTICLES



Treatment of Influenzal Meningitis

Abraham Levinson, M.D.
Chicago

Influenzal meningitis, even more so than other types of bacterial meningitis, reflects the rapid progress medicine has made during the past few years. In a comparatively short period, the treatment of this type of meningitis has changed several times. In order to evaluate the various methods of treatment of this disease, we are presenting a study of 60 cases of influenzal meningitis treated by us at the Children's Division of the Cook County Hospital from January 1942 to June 1948, with a comparison of the results of each type of treatment. Our study also threw light on the question whether intrathecal therapy is necessary in the treatment of meningitis.

TYPE OF TREATMENT

Our cases are divided into two main groups:

1. Those treated without strepomycin.
2. Those treated with streptomycin.

From the Children's Division of the Cook County Hospital and from the Hektoen Institute for Medical Research.

A review of the tables shows our results according to the two types of treatment. the cases treated with sulfa, penicillin and serum without streptomycin had a mortality of 48.5%, and those with streptomycin had a general mortality of 9.8%.

The cases treated without streptomycin are further broken down to the following subdivisions:

Sulfonamides alone, 6 cases, 6 deaths - 100% mortality.

Sulfonamides and Alexander Serum, 12 cases, 6 deaths - 50% mortality.

Sulfonamides, penicillin and Alexander Serum, 9 cases, 1 death - 11.9% mortality.

Sulfonamides and penicillin, 2 cases, 1 death- 50% mortality. (Table 1)

The mortality in our cases of influenzal meningitis treated by streptomycin is as follows:

Of the 12 cases treated by streptomycin, sulfa, pencillin and serum 3 died, a mortality of 25% (Table 2). All of the 17 cases that were treated by streptomycin and sulfa recovered (Table 3 A

TABLE 1

RESULTS OF TREATMENT OF INFLUENZAL MENINGITIS WITHOUT STREPTOMYCIN

	Name	Age	TREATMENT Sulfonamide	Alexander Serum (in mg.)	Penicillin	Results
1.	D. K.	13 mo.	Diazene			D
2.	S. K.	23 mo.	Diazene			D
3.	C. J. H.	6 mo.	Pyridine			D
4.	T. N.	3 mo.	Merazine, Diazine			D
5.	R. A.	11 mo.	Thiazole			D
6.	M. C.	18 mo.	Thiazole			D
7.	R. S.	7 mo.	Diazene	50		D
8.	C. C.	2 mo.	Diazene, Pyridine	50		R
9.	B. N.	6 mo.	Pyridine	50		D
10.	R. M.	2 yrs.	Diazene	75		R
11.	J. P.	10 mo.	Diazene	50		D
12.	P. S.	8 mo.	Pyridine	150		D
13.	S. A.	18 mo.	Diazene	100		R
14.	M. J. B.	21 mo.	Diazene	150		D
15.	J. K.	11 mo.	Merazine, Diazene	50		D
16.	L. B.	7 mo.	Diazene	100		R
17.	R. D.	24 mo.	Diazene	50		R
18.	J. C.	23 mo.	Diazene	75		R
19.	D. S.	14 mo.	Diazene	50	X	R
20.	D. S.	3 mo.	Diazene		X	R
21.	D. V.	3 mo.	Thiazole		X	D
22.	R. B.	18 mo.	Diazene	50	X	R
23.	L. G.	12 mo.	Diazene	50	X	R
24.	A. W.	4 mo.	Diazene	25	X	R
25.	N. M.	5 mo.	Diazene	50	X	R
26.	R. C.	12 mo.	Diazene	50	X	D
27.	J. G.	8 mo.	Diazene	100	X	R
28.	J. M.	16 mo.	Diazene	50	X	R
29.	F. B.	7 mo.	Diazene	150	X	R

TABLE 2

Influenzal Meningitis Treated with Streptomycin, Sulfa, Penicillin and Serum

	Name	Age	Streptomycin I. M. 100,000 U. every 3 hours	Streptomycin I. T. 100,000 U. daily	Sulfa-diazene	Penicillin	Alexander Serum	Results
1.	M. W.	6 mo.	X		X	X		R
2.	M. D.	10 mo.	X		X	X		R
3.	D. E.	2 yr.	X	X	X	X	X	R
4.	R. D.	9 mo.	X	X	X	X	X	R
5.	H. A.	18 mo.	X	X	X	X	X	R
6.	S. P.	11 mo.	X	X	X	X	X	R*
7.	C. H.	5 mo.	X	X	X	X	X	D
8.	S. A.	7 mo.	X	X	X	X	X	D
9.	D. S.	20 mo.	X	X	X	X		R
10.	J. T.	8 mo.	X		X	X	X	R
11.	J. C.	2 yr.	X		X	X	X	R
12.	M. G.	3 mo.	X		X	X	X	D

* with post encephalitic sequellae

TABLE 3A

Influenzal Meningitis Treated with Streptomycin, 100,000 Units Every 3 Hours, (Intramuscularly Only) and Sulfadiazine

	Name	Age	Strepto-mycin - I.M.	Sulfa-diazine	Results
1.	D. W.	10 mo.	100,000 units every 3 hours	X	R
2.	W. C.	6 mo.	X	X	R
3.	S. S.	5 yr.	X	X	R
4.	J. G.	4 mo.	X	X	R
5.	A. L. M.	5 wks.	X	X	R
6.	S. S.	5 mo.	X	X	R
7.	J. D.	10 mo.	X	X	R
8.	C. J.	14 mo.	X	X	R
9.	P. H.	6 mo.	X	X	R
10.	F. H.	10 mo.	X	X	R
11.	A. J.	2 yrs.	X	X	R

TABLE 3B

Influenzal Meningitis Treated with Streptomycin, 300,000 Units Every 6 Hours (Intramuscularly Only) and Sulfadiazine

	Name	Age	Strepto-mycin-I.M.	Sulfa-diazine	Results
12.	J. A.	4 yrs.	300,000 Units every 6 hours	X	R
13.	B. W.	5 mo.	X	X	R
14.	D. C.	14 mo.	X	X	R
15.	C. P.	13 mo.	X	X	R
16.	A. H.	12 mo.	X	X	R
17.	H. C.	4 yr.	X	X	R

and B). 2 cases have been treated with streptomycin only, and both recovered (Table 4).

In spite of the two recoveries on streptomycin alone, we continue to combine sulfadiazine with streptomycin in order to treat secondary invaders, which are not uncommon in influenzal meningitis.

ROUTE OF ADMINISTRATION

Originally, we gave streptomycin both intramuscularly and intrathecally. In the last series of 22 cases, however, all the streptomycin was given only intramuscularly. In spite of the intrathecal therapy some of the patients died. In the last series there were no deaths, demonstrating that no intrathecal therapy is necessary. This was found to be the case also in tuberculous meningitis (to be published), in which the cases that improved had no intrathecal streptomycin. This confirms the original work of Hayne.

DOSAGE

The dosage of streptomycin we employed originally in the treatment of influenzal meningitis was 100,000 units intramuscularly every 3 hours. In the last 6 cases we administered 300,000 units intramuscularly every 6 hours and the patient recovered. We therefore believe that 300,000 units of streptomycin every 6 hours is the proper method of treatment.

LENGTH OF TREATMENT

We have been feeling our way as to the length of time streptomycin treatment is to be continued. Early, we gave streptomycin for 14 days, then we reduced it to 8 days and now we continue it until the patient stays afebrile for 3 days. The average length of streptomycin treatment in the last series has been 7 days.

As to sulfonamides, we use sulfadiazine and give it intravenously to begin with, with an average of 3 grains of sodium sulfadiazine per pound of body weight in 24 hours. Gradually, we reduce the sulfadiazine to 1 grain per pound and as soon as possible we administer it by mouth. We continue the sulfadiazine for 5 days after the streptomycin is discontinued.

Next to treatment, the following data has been interesting.

ETIOLGY

Incidence. — Influenzal meningitis ranked third in frequency of the cases of meningitis treated at our hospital, meningococcic meningitis being first and tuberculous meningitis second in frequency. Influenzal meningitis accounted for slightly less than 20% of our meningitides.

Bacteriology. — Practically all cases of influenzal meningitis are caused by type B of Hemophilus Influenzae bacillus. In the majority of our cases the organism quelled with the Alexander Serum.

Predisposing Causes. — Sinusitis is the most important predisposing factor in influenzal meningitis. Pneumonia and otitis media are also important predisposing factors.

Season. — Fall and winter with their inclement weather, predispose to this type of meningitis. Cases, however, do occur any time of the year.

Sex plays no role.

Age. — Our youngest patient was 5 weeks old and our oldest 5 years. The largest number of

TABLE 4
Influenzal Meningitis Treated With Streptomycin Only

	Name	Age	Streptomycin-I.M. Results 100,000 U. every 3 Hours	
1.	J. P.	7 mo.	X	R
2.	S. N.	8 mo.	X	R

cases was under 2 years of age (52 out of 60 cases). Influenzal meningitis is thus a disease of infancy (Table 5).

TABLE 5
Age of Patients with Influenzal Meningitis

	No. of Cases
Under 6 months	12
6 to 12 months	23
1 to 2 years	17
2 to 3 years	5
3 to 5 years	2
5 years	1
TOTAL	60

PATHOLOGY

The pathology of the meninges is the same as in any other form of meningitis. Influenzal meningitis, however, is more frequently accompanied or complicated by pathology of the respiratory tract. Of particular interest was a case of influenzal meningitis which followed intestinal intususception and which has been operated on.

SYMPTOMATOLOGY

Since the greatest frequency of influenzal meningitis is among infants, the symptoms are not always typical of meningitis. The classical meningitic signs may even be absent. A bulging fontanelle is the most frequent objective symptom in young infants.

RECURRENCE

1 case recurred several months after recovery. The patient was treated by streptomycin during the first attack.

SEQUELLAE

Of the cases treated without streptomycin one developed a severe hydrocephalus, one developed blindness and deafness and another one had repeated convulsions and mental retardation. Of the cases treated with streptomycin, 2 developed post-encephalitic symptoms. One of them became mentally deteriorated and the other developed personality changes.

BLOOD

There was a polymorphonuclear leucocytosis in 98% of the cases. In 2% there was a leucopenia. The blood culture was positive in 50% of our cases.

CEREBROSPINAL FLUID

The cerebrospinal fluid was cloudy in all of our cases. The cells varied from 800 to several thousand per cubic m.m. The protein was greatly increased and the sugar was markedly reduced or absent. The organisms were recovered from the cerebrospinal fluid both in smear and in culture in 100% of the cases. The cerebrospinal fluid became sterile as a rule on the fourth day of treatment. The cells usually decreased to 100 or less on the fourth day. The glucose increased and the protein decreased.

SUMMARY AND CONCLUSION

We studied 60 cases of Influenza Meningitis at the Children's Division of the Cook County Hospital between 1942 and 1948.

The age of the patients varied, between 3 weeks and 5 years, but the majority of the cases were under 2 years of age.

The results of treatment in the 60 cases were as follows:

Sulfonamides alone — 6 cases — 6 deaths — 100% mortality.

Sulfonamides and serum — 12 cases — 6 deaths — 50% mortaity.

Sulfonamides, serum and penicillin — 9 cases — 1 death — 11.9% mortality.

Sulfonamides and penicillin — 2 cases —1 death — 50% mortality.

Streptomycin, sulfonamides, penicillin and serum —12 cases — 3 deaths — 25% mortality.

Streptomycin and sulfadiazine — 17 cases — no deaths.

Streptomycin alone — 2 cases — no deaths.

Streptomycin is of definite value in the treatment of influenzal meningitis and should replace all other types of treatment, but whether it can be used alone or in combination with sulfonamides time will tell. At present, we advise to treat all cases with streptomycin and sulfa, in spite of the fact that 2 cases recovered on streptomycin alone.

We advise to give 300,000 units every 6 hours.

The streptomycin should be given intramuscularly only. No intrathecal therapy is necessary.

The streptomycin should be administered for 7 days. However, if the patient does not show marked improvement, it should be continued longer. The sulfadiazine should be continued for 12 days.

Serum should be used only in very stubborn cases when the response to streptomycin and sulfa is of no avail.

30 N. Michigan Ave.

The Management of Labor

L. A. Calkins, M.D., Ph.D.
University of Kansas Medical Center
Kansas City, Kansas

American physicians can be justly proud of the advances made in prenatal care in the past generation. Marked improvements have also come in the care of women after delivery. The care of the woman in labor, however, has received relatively little attention, with two general exceptions. Widespread and still continuing efforts have been expended to improve pain relief. Extensive studies of the proper indications of operative procedures have also been presented to us. Almost no effort has been directed toward a better understanding of the basic physiology of labor, except several recent studies of the third stage.

Too long have we thought of labor as a single continuous process. Too long have we considered the "art" of the management of labor. Aphorism and obstetrical dogma still guide many of our actions rather than sound scientific truth.

Text books have consistently told us that labor is divided into three stages. It has been rather clearly stated that the first stage has to do with effacement and dilatation of the cervix. The second stage has to do with the expulsion of the baby, and the third stage has to do with the separation and the expulsion of the placenta. Quite clearly, these are three separate and distinct processes. The only evidence that they are in any way similar to one another is that they follow upon one another, and all three are associated with uterine contractions. The latter point is not good evidence, since it is well known that uterine contractions are present throughout pregnancy and continue in many patients, quite violently, into the first several days of the puerperium. Careful observation of several successive labors will convince anyone that the former point is no more cogent, and that the three stages of labor are really three separate processes, each with its own fundamental physiology and each, therefore, demanding its own proper management.

The First Stage. — The first stage of labor has to do with the effacement and dilatation of the cervix, or, to put it another way, the removal of the cervix as an obstruction to the delivery of the baby. It is the "cervical stage" of labor. The only factors concerned in this stage of labor are the contractions of the uterus on the one hand, and the resistance to dilatation offered by the cervix on the other hand. Weak and infrequent uterine contractions will dilate the cervix only slowly, or perhaps not at all. Strong and frequent contractions will do the job much more quickly. A firm, thick cervix will resist dilatation much more markedly than a soft, thin one. We pointed out several years ago that the length of any given labor could be predicted to an exact number of hours — almost to minutes — by examining the patient carefully at the onset of her labor, and noting the intensity and frequency of her uterine contractions and the length, thickness, and consistency of her cervix. Nothing else matters. The long-standing belief that a short, fat woman has a long labor is not true. A large baby does not prolong the

Presented before the 108th annual meeting, Illinois State Medical Society, Chicago, May 10-12, 1948.

first stage of labor. Abnormal presentations are not productive of difficulty, and "dry labor" is not a proper explanation of a prolonged first stage. Any or all of these above named items may subseqnently be found to affect the character of uterine contractions to a limited extent, but, in the present stage of our knowledge, they need not be considered. What we do need to analyze in each and every patient is uterine contraction and cervical resistance.

Management of the patient in the first stage, therefore, has three objectives: (1) avoidance of anything that will materially interfere with uterine contractions on the one hand, of cervical resistance on the other; and the employment of anything possible to improve this relationship; (2) maintenance of the best possible condition in the patient as a whole; (3) relief of pain. Opinions as to how all three of these objectives can be best attained will naturally differ widely from one physician to another. There can, however, be no logical difference of opinion as to the basic principles involved.

It is common observation that the cervix remains relatively firm throughout pregnancy, and, even in some patients, to within a few hours of the onset of labor. For some, as yet unexplained, reason, there is usually a considerable softening of the cervix sometime in the last twenty-four hours before labor begins. It is also common knowledge that painless (Braxton-Hicks) contractions of the uterus continue throughout pregnancy, and, at times, may become quite painful. This is particularly true at the time of lightening. A small percentage of patients complain of short periods of "labor pains" for several weeks before the onset of true labor. These may occur in more intensive form in the last several hours before what, on close observation, must be the true labor. It is, therefore, difficult in the occasional patient to know when labor begins. Careful observation of the patient for several successive uterine contractions will, however, reveal the fact that the patient is not going to deliver soon. Such an individual, unmanaged, tends to become fretful, fearful, fails to take proper nourishment, and, after several hours, becomes mentally exhausted and — somewhat later — physically exhausted. Proper management and "moral support" obviates these difficulties. Food and fluid intake must be maintained, fear dispelled, body excretions supervised, and physical rest provided when necessary. To attain these objectives may mean long hours, even days, of the physician's time, as it is rarely possible to entrust these duties to other than the most experienced nurses.

There is nothing to fear with respect to either mother or baby from weak and completely ineffectual pains, or from the true labors which are slow either because of poor contractions or resistant cervix. The pathologically hard cervix, or rigid cervix, is so rare that one needs only to caution that there is such a possibility, and that normal labor should not be expected, but Cesarean Section resorted to. Slow labor, then, is a trial to the doctor, the patient, and the patient's family; but not a cause for grave concern. Rapid labor, on the other hand, particularly when due to violent uterine contractions, is a serious menace to the life of the baby, and, at least, to the tissue integrity of the mother. It is unfortunate that we do not have a simple mechanism available to all whereby the intensity of uterine contractions can be actually measured. Digital palpation of the uterus at the height of uterine contraction will, however, give us sufficient information, if we remain constantly alert to differentiate between the weak contraction, the normal average contraction, and the too intense contraction. It is by this palpation of uterine contractions that we can predict the progress which may be expected, and it is also by this means that we can determine the need for and probable effect of any analgesic or anesthetic. One cannot stress too much the importance of frequent palpation of the uterus.

Pain intensity may vary markedly as labor progresses. It is perfectly futile to give drugs or milder anesthetic agents in the presence of violent uterine contractions. Only deep chloroform or ether anesthetic will affect such contractions. It is also to the disadvantage of the patient to administer even moderate doses of analgesics in the presence of weak and infrequent contractions, unless it is definitely desired to provide the patient with a rest period. The best medication for this purpose is morphine. It is futile to give as little as 1/8 grain for this purpose. All analgesic and anesthetic drugs have some deterrent effect on uterine contractions. The stronger the contraction, the less effect will be observed from a given dosage. Pains of good intensity are not markedly altered by ordi-

nary therapeutic dosages. Weak pains may be very markedly altered. In such patients, the labor will, from natural causes, be quite long enough. Under these circumstances, we would like to give the patient a uterine stimulant. Unfortunately, no safe stimulant has so far been devised. The use of posterior pituitary extract has been, and still is, a very dangerous practice. Doses so small as to produce no result in one patient may well have a violent effect in the next patient. The upright position is very helpful on the whole, and, in some patients, will result in progress where otherwise no progress would take place. Little, if any, result can be expected from the exhibition of Quinine, and hardly more from the use of abdominal binders, except in those patients with marked diastasis recti. One must not overlook the fact that proper rest periods may actually shorten labors, even though the patient sleeps without uterine contractions for a period of several hours. Such rest periods can, in general, not be secured when uterine contractions are frequent and of good entensity, but only when weak and infrequent pains are becoming weaker and still more infrequent.

It is interesting to note that hard working farm women and city athletes rarely have long labors. It has been our feeling for many years that all patients can approach the avoidance of long labor by regular, daily, outdoor walks in the last six weeks of pregnancy. It is also common observation that most of the long labors occur in girls who may not have wanted to become pregnant in the first place, and who are very fearful of their approaching labor and of each and every event in that labor. Grantly Reid and his few disciples have told us that we can dispel a large proportion of this fear by proper advice and encouragement, if we begin early in the pregnancy and continue through the labor. Personal observation will verify that this is, at least partly, so. We can well afford to pay more attention to the psychic aspects of pregnancy, of labor, of the puerperium, and even of child care.

The Second Stage — The second stage, in the light of our present knowledge, is a complicated process, with many factors involved. It is, however, accomplished easily and quickly in the average patient. Here again, intensity and frequency of uterine contractions are very important. On the expulsive side, there is added a considerable voluntary effort. This is uniformly quite intense in the primitive woman and much less marked among the cultured. It is also inhibited when any considerable degree of fear is present. It is not natural for the patient to exert expulsive efforts in the first stage, and such effort should not be encouraged at that time. In the second stage, however, prohibition of voluntary effort by the attendant is next to impossible, except by deep anesthesia. Not only is voluntry effort highly desirable in the second stage, but often very necessary in the presence of weak uterine contractions. It is difficult to decide which is more important in many patients. Many multiparas, of course, deliver themselves by voluntary effort alone. This is occasionally observed in a primipara.

On the resistant aspect of the second stage, one must consider the vaginal walls and pelvic floor, the size of the infant, the degree of flexion of the head, and the time at which internal rotation takes place. No one of these latter factors is very important, nor will it delay delivery very much, except where the uterine pains are very poor and voluntary effort is lacking. If several of these factors are present and are associated with poor pains and lack of voluntary effort, marked delay of the delivery may occur, and operative intervention may become necessary. The main points, therefore, in management of the second stage have to do with the preservation of good uterine contractions, if present, and the maintenance of the patient's ability to exert voluntary effort. Since it is necessary to uniformly administer anesthesia or analgesia in the second stage, the problem is to make certain that the correct degree of anesthesia is maintained. Ether and chloroform have long been known to markedly inhibit uterine contractions, when given in sufficient amount to produce real anesthesia. Caudal anesthesia does not interfere so much with uterine contractions, but entirely abolishes reflex voluntary effort. There is some indication that minimal dose saddle block may be a workable procedure, so far as voluntary effort is concerned. It does not seem to markedly inhibit uterine contractions. Nitrous oxide, expertly administered, has fulfilled both of these qualifications, and been widely used for many years.

The vaginal walls offer almost no resistance to descent in the occiput presentation patients. As a matter of fact, this descent takes place dur-

ing the latter part of the first stage in the majority of patients, and the head is already firmly against the pelvic floor as the cervix recedes over the head. In the majority of the remaining patients, descent to the pelvic floor occurs in the next one to three uterine contractions, and will be uniformly found to have occurred within ten pains. Failure of descent, therfore, is either due to lack of complete dilatation and retraction of the cervix, or pathology in the form of abnormal presentation, hydrocephalus, etc. A vaginal examination should, therefore, be made under sterile precautions in all such cases.

Negotiation of the pelvic floor, whether by the head on the pelvic floor at the time dilatation is complete or by one descending very soon thereafter, is uniformly accomplished within ten pains in all multiparas and in the majority of primiparas, who have good pains. If the primipara's pains are poor, a few more contractions can be expected. Even so, approximately 90% will have delivered within twenty pains or less, and forceps delivery should be considered if the labor is delayed much beyond twenty or twenty-five pains, after one is absolutely certain that the cervix has retracted and that he is dealing with an occiput presentation.

Counting of the labor pains in the second stage has given us much better results than watching the clock. It has improved our clinical judgment as to what constitutes proper progress, and incidentally has reduced our incidence of forceps delivery. Episiotomy will naturally shorten the second stage by one or two pains and may, there fore, be indicated where speed is necessary. Otherwise, it is doubtful whether the final tissue result in the mother is improved by this procedure.

The Third Stage — Our text books have consistently told us that the third stage has two phases. First, separation of the placenta and membranes from the uterine wall takes place spontaneously and very satisfactorily, with rare exceptions. *It is only necessary that we do not interfere.* In the words of the late Whitridge Willaims, "do not bedevil the uterus". Following separation of the placenta, bleeding, either apparent or hidden, behind the placenta, may well take place, unless this structure is promptly expressed. It, therefore, becomes important to recognize placental separation. Immediately after delivery of the baby, the uterus is flattened from before backward and has a rather sharp superior margin. Within a matter of seconds in the average patient, the uterus assumes a truly globoid shape with a broadly rounded superior margin. This change in shape of the uterus has uniformly meant placental separation in our hands. It is our procedure to now briskly massage the uterus, in order to gain the firmest possible contraction. Little or no attempt is made to push the placenta out. If expression of the placenta becomes necessary, it should be done largely by squeezing the uterus with as little downward pressure as possible. The uterus should, at all times, be kept up out of the true pelvis. Following delivery of the placenta, firm uterine contraction should be maintained by massage and, or, the use of oxy-toxic drugs. Posterior Pituitary Extract intra-muscularly, or the newer Ergotrate preparations intra-venously, are very helpful for this purpose. Close attention to the maintenance of firm contraction of the uterus should be maintained for a minium period of one hour. It is also well not to move the patient about for a minimum period of one to two hours. This is especially important in cases of placenta previa and other bleeding patients. A hypodermic of morphine, given immediately after the delivery of the baby, will add materially to the patient's comfort. Most patients also appreciate a hot drink at this time.

This general plan of management of labor, although quite undramatic, has served us well over a long period of years and brought good results for both mothers and babies.

Studies in the Oral Administration of Penicillin

III Oral Penicillin in the Treatment of Pneumococcic Pneumonia

Italo F. Volini, M.D., Wm. Hoffman, M.D., J. R. Hughes, M.D. and J. R. Peffer, M.D., Chicago

Since the isolation of penicillin associated with the discovery of its antibacterial properties[1], numerous studies have been made to determine the efficacy of this type of therapy in infectious diseases. It has proven itself unequivocably as one of the most potent therapeutic agents in the treatment of pneumococcic pneumonia. It is general knowledge that its toxic complications are less marked than those encountered with the use of its chemical predecessors. Parenteral penicillin therapy, however, is still handicapped because of the necessity for injection associated with this mode of adminstration. It is apparent that there is a need for a substitute method of administration utilizing the same marked antibacterial properties so that it could be taken as simply as the sulfonamide drugs.

In the past two years, the evidence has continued to accumulate indicating that orally administered penicillin is capable of producing adequate therapeutic blood levels. However, there has been considerable difference of opinion as to best method for oral usage. McDermott, Saeger, Free etal, Little and Lumb, Charney, Gyorgy, Paul and his associates, Finland, Meades, Burke and others have contributed much to our information of penicillin activity when adminstered orally. Definite knowledge, however, is not yet certain concerning all of the factors such as rate and degree of absorption and the action of the gastrointestinal tract and its secretions on penicillin.

Bunn, McDermott etal[2], also Hoffman and Volini[4] have published satisfactory results recently on the use of oral penicillin in pneumonia. The latter authors in a previous paper[3] indicated that in 100,000 unit dosage preceded by a 200,000 unit initial dose, there was no great variation in blood levels regardless of the preparations used. Controversies pertaining to the use of buffered and unbuffered penicillin are still unsettled. The essential factor most obvious is to obtain satisfactory therapeutic blood levels. If this is possible, clinical results should correspond with those obtained in the use of parenteral penicillin. It is the purpose of this paper to furnish additional results in unselected cases of pneumococcic pneumonia following the use of oral penicillin.

Method of Study.—This report includes a study of 48 patients with pneumococcic pneumonia treated at the Cook County Hospital with oral penicillin. All cases admitted to the hospital presenting clinical signs of lobar pneumonia were included in the study regardless of age and associated complicating diseases. Blood cultures and sputum specimens were obtained as soon as possible after admission. The sputum type was determined by the Neufeld Reaction. Sputum cultures and mouse inoculation were used if needed. All sputum and blood specimens were collected prior to therapy. Within 24 hours after the initial dose of medication, blood was drawn for a penicillin level in most cases. The interval of time between this and the last medication given was noted and recorded.

No other form of specific therapy was used except supportive and symptomatic treatment which was instituted where deemed necessary. Chest x-rays and flouroscopic examinations were made when clinical findings were questionable. All patients in this series were visited daily and individual records were kept of temperature variations and physical findings.

Dosage and Method of Drug Administration.—The penicillin was used in the form of tablets

From the Hektoen Institute for Medical Research of the Cook County Hospital and the Departments of Medicine of the Cook County Hospital and the Loyola University School of Medicine.

Aided by a grant from the Commercial Solvents Corporation, Terre Haute, Indiana.

Read before the General Assembly 107th Annual Meeting Illinois State Medical Society, Chicago, May 12, 1947.

TABLE 1

Classification of Cases Studied

Total No. Cases Studied	48
Total No. Typed Pneumococcic Pneumonias	25
Total No. Friedlander's Pneumonia	1
Isolated Pneumococci Failing to Type	1
Total No. Cases of Undetermined Etiology	21

TABLE 2

Typed Pneumococcic Pneumonias

Types	No. Cases	Bacteremias	Fatal Cases
I	4	3	
II	9	4	1
III	1		
IV	2	1	
V	1		
VI	2		
VII	1		
VIII	1	1	
X	2		
XVI	2		
Pneumonias isolated failed to type	1	1	1
Total no. typed Pneumococcic Pneumonias	25	10	1
Friedlander's Pneumonia	1		
Undetermined etiology	21		

each containing 100,000 units prepared with hydrogenated fat, salts of fatty acids and starch. The penicillin was pure crystalline potassium penicillin assaying slightly over 1500 units per miligram and containing over ninety-five per cent of Penicillin G. One tablet 100,000 units was administered every three hours around the clock at 3, 6, 9, 12 o'clock during the twenty-four hours awaking the patient through the night on hours indicated. A primary dose of 200,000 units was given shortly after admission

TABLE 3

PENICILLIN BLOOD LEVELS

Hours	Low	High	No. Cases	Average
		Intramuscular Penicillin		
½	0.25	0.50	2	0.375
1	0.06	1.00	4	0.45
1½	0.06	0.125	6	0.092
2	0.30	0.50	23	0.143
2½	0.06	0.125	9	0.096
3				
		Oral Penicillin		
1	0.06	0.5	6	0.161
1½	0.06	1.0	6	0.259
2	0-.03	1.0	16	0.154
2½	0-.03	0.5	8	0.115
3	0-.03	0.125	8	0.093

to the hospital after the diagnosis of pneumonia was made. The next dose of 100,000 units was given when the clock hands reached 3,6,9 or 12 o'clock on the clock dial. No particular effort was made to separate medication from the ingestion of food. On the schedule outlined at the Cook County Hospital, the adminstration of medication and food occurred together only at the noon time meal. Thus therapy was administered to all patients as soon as possible after admission usually within the first hour. The drug was continued until the patient was afebrile for 48 to 72 hours. This method of dosage and drug administration has been reported by us as producing plasma penicillin levels of 0.06 units per c.c. or higher during most of the three hour interval between doses.

These assay studies reveal plasma levels well above the necessary concentration found in vitro studies to sterilize cultures of the great majority of strains of the pneumococcus. Included with the pneumococcus can be added Group A Hemolytic Streptoccocus, gonococcus and most

TABLE 4

Febril Response Following Oral Penicillin

	Total Cases	%	Typed Pneumococcic Pneumonias	%	Pneumonias of Undetermined Etiology	%
24 hours	18	37.5	10	37.0	8	38.1
48 hours	10	20.8	*5	18.6	5	23.8
Total within 72 hours	30	62.4	15	55.6	15	71.4
Over 72 hours	15	31.3	10	37.0	5	23.8
Expired	3	6.3	2	7.4	1	4.8
Total	48	100.0	27	100.0	21	100.0

*Includes one case of Friedlanders Pneumonia

TABLE 5

Analysis of Age and Mortality Following Oral Penicillin

Age	Total Cases No.	%	Deaths No.	Mortality % 48 Cases
Under 50	31	64.6	1	3.2
Over 50	17	35.4	2	11.8
Totals	48	100.0	3	6.3

TABLE 6

Analysis of Severity of Illness

Total Typed Pneumococcic Pneumonias	52.1%
Incidence of Types 1, 2, 3, 7 & 8	62.0%
Bacteremia	38.0%
Duration Disease Prior to Rx	3.78 days
Multilobar Involvment	29.2%
Average Duration Treatment	5.8 days

TABLE 7

Associated Disease in Pneumonias Treated with Oral Penicillin

Chronic Alcoholism	6
Cirrhosis Liver	2
Pulmonary Tuberculosis	3
Hypertensive Heart Disease	1
Bronchial Asthma	1
Bronchiectasis with Marked Pulmonary Osteoarthropathy and Generalized Arteriosclerosis	1
Arteriosclerotic Heart Disease with Auricular Fibrillation and Decompensation	1
Rheumatic Heart Disease Compensated	1
Acute Pyelitis	1

of the strains of streptococcus viridans. Staphylococcus Aureus and meningococcus are more resistant as are also some strains of streptococcus viridans from cases of subacute bacterial endocarditis.

RESULTS

There were a total of 26 typed pneumococcic pneumonias in the series of 48 cases (Tables 1, 2, and 6). Sixty-two percent of these were included in types I, II, III, VII and VIII indicting a majority of the more severe pneumococcus invaders. Furthermore, ten cases or 38% (Table 2) of the 26 typed patients proved to be bacteremic with 4 (30%) and 9 (40%) respectively of type I and type II pneumococci. It is apparent from these figures that the cases studied can be considered as the severe type of pneumonia encountered during the peak of the winter season.

The majority of the patients studied were less than fifty years of age, 31 or 64.6% (Table 5) the remaining 17 (35.4%) in the older age group.

TABLE 8

Total Dose Oral Penicillin

Average total	4,410,000 units
Maximum total	14,400,000 units
Minimum total	2,100,000 units

TABLE 9

Complications in Pneumonias on Oral Penicillin

	No. Cases	Percentage	Died
Empyema	3	6.3%	1
Pleural Effusion	3	6.3%	0
Pneumococcic Meningitis	1	2.1%	1
Toxic Hepatitis	1	2.1%	1

TABLE 10

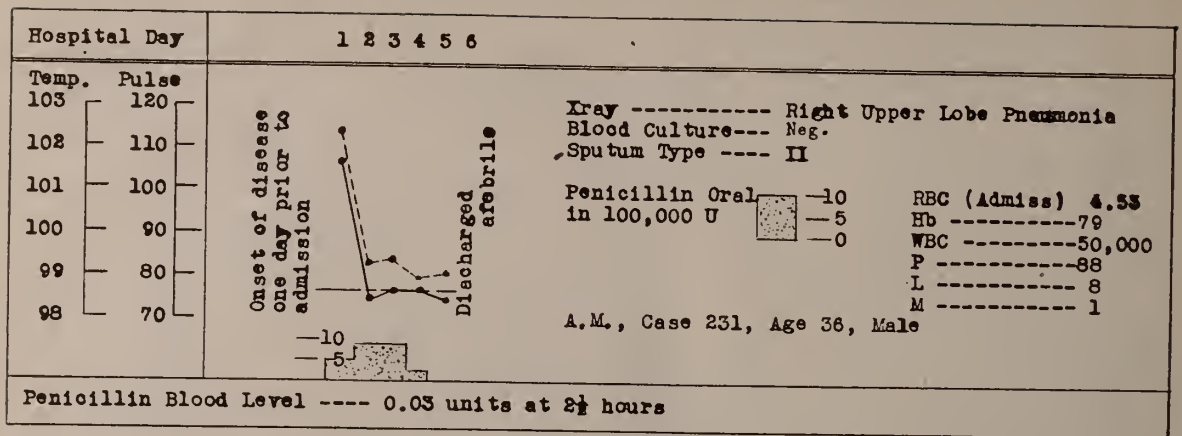
Duration Treatment

Average	5.8 days
Maximum	20.0 days
Minimum	3.0 days

The mortality rate was higher in the older group as would be expected being more than three times that of the patients under fifty years of age. In both age groups, there were 5 cases which showed no response to penicillin therapy but as is indicated later, each of these could not be considered a typical uncomplicated case of lobar pneumonia. The total death rate 6.3% of all cases can be considered as similar to other reported mortality rates in pneumonia patients on chemo or antibiotic therapy; sulphathiazole 12.7% and paranteral penicillin 11.1%[5], combined penicillin and sulfadiazine therapy 6.7%[6], and sulfapyridine 4%[7], sulfadiazine 9.6%[11] and sulfamerazine 11%[10]. It is interesting to note that not only was the mortality rate higher in the older group of patients but the incidence of cases failing to respond to therapy was higher also.

The average duration of disease prior to treatment was 3.78 days (Table 6) and the average duration of treatment was 5.8 days. Since all of the patients treated in this series were kept on therapy for three days after the subsidence of fever, one would assume that the average duration of the disease after the onset of therapy was 2.8 days. As is illustrated in Table 4, 62.4% of the patients became afebrile within 72 hours and 20.8% responded in more than 72 hours. This constituted 10 cases of the entire group, all of which became afebrile within the next 48 hours

Chart I

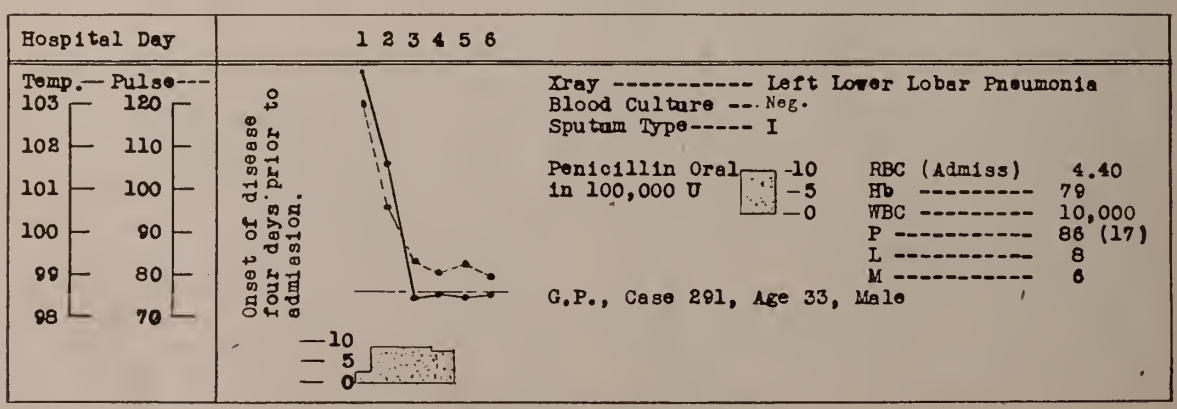


Typical febrile response to Oral Penicillin

or a total of five days. All patients maintaining fever for a longer period of time were included in the "no response group" 10.5%. Eighteen cases demonstrated a rapid febrile decline within 24 hours. The majority of these however were treated very early, within 24 to 48 hours after the onset of the initiating symptoms of the disease. Ten (20.8%) of the 48 cases responded in two days with 58.3% response in 48 hours including the 24 hour group. This is considerably lower than the 48 hour (77%) response reported in a previous paper (3). However, this latter figure represents the effect of oral penicillin therapy on a selected group of patients with manifest symptoms of uncomplicated pneumonia. Also, in the previous report, the type of pneumococcus and the presence of bacteremia were not routinely determined to indicate the virulence of the invading organism.

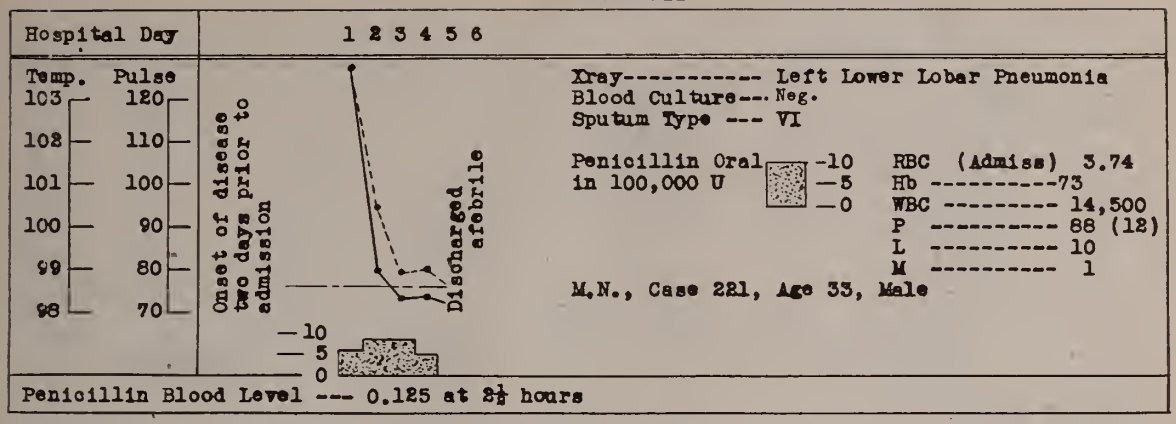
Clinical Response.—Chart I is a typical illustration of the early fall of temperature by crisis that was noted in most of the cases studied. In a charity institution such as Cook County Hospital, prolonged exposure and a greater tendency toward malnutrition must be considered in evaluating response to therapy of disease. As is mentioned above, the average febrile period following treatment was approximately 2.8 days or 67.2 hours. It is difficult to diagramatically represent such a response as an indication of the clinical course of all cases studied. This diagram is characteristic of the febrile course of the majority of the patients indicating its rapid abrupt fall to normal. The usual clincal response to oral penicillin is, in most cases, as dramatic as that of the parenteral form of adminstration of the drug, and in uncomplicated or selected cases,

Chart II



Typical febrile response to Oral Penicillin

Chart III



Typical febrile response to Oral Penicillin

Chart IV

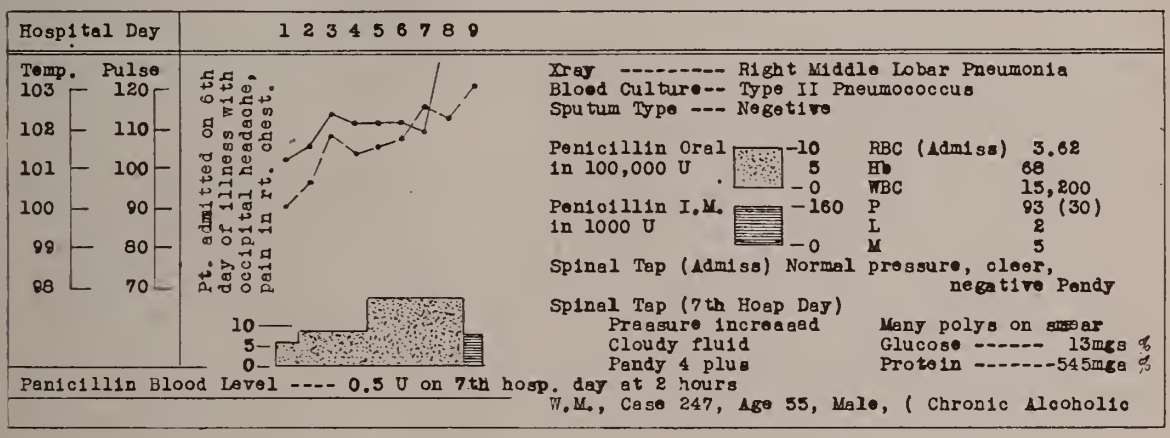


Chart V

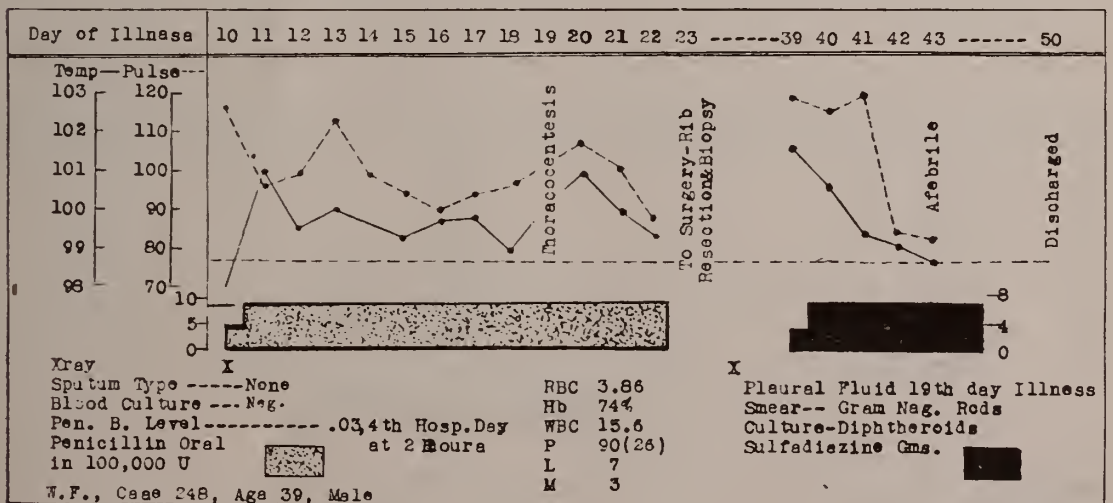
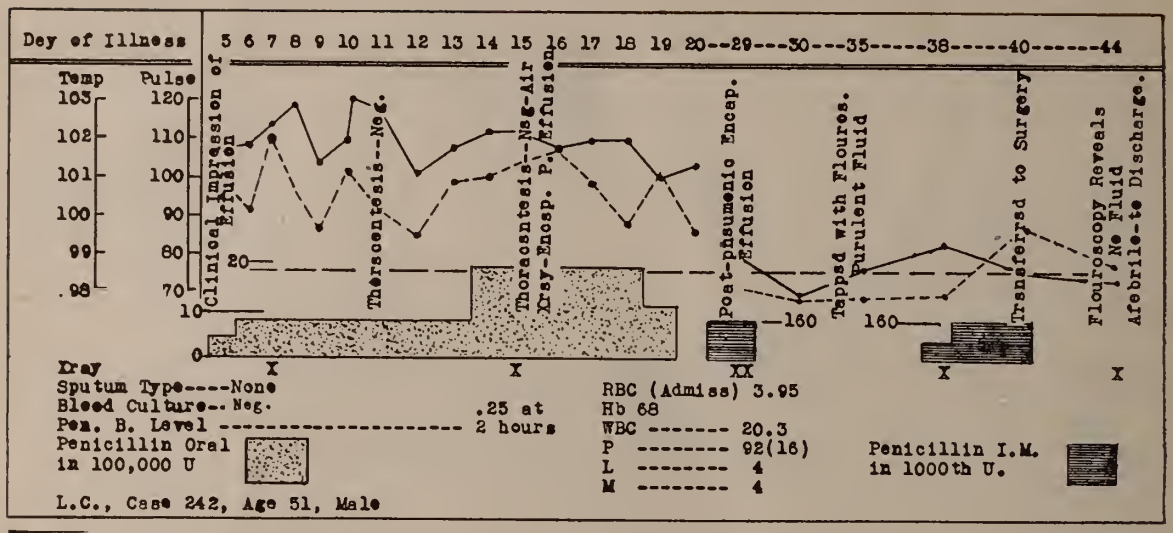


Chart V.-- Clinical course and illustration of duration of illness following surgical drainage in a case of empyema included in " no response group "with broncho-pleural fistula.

Chart VI

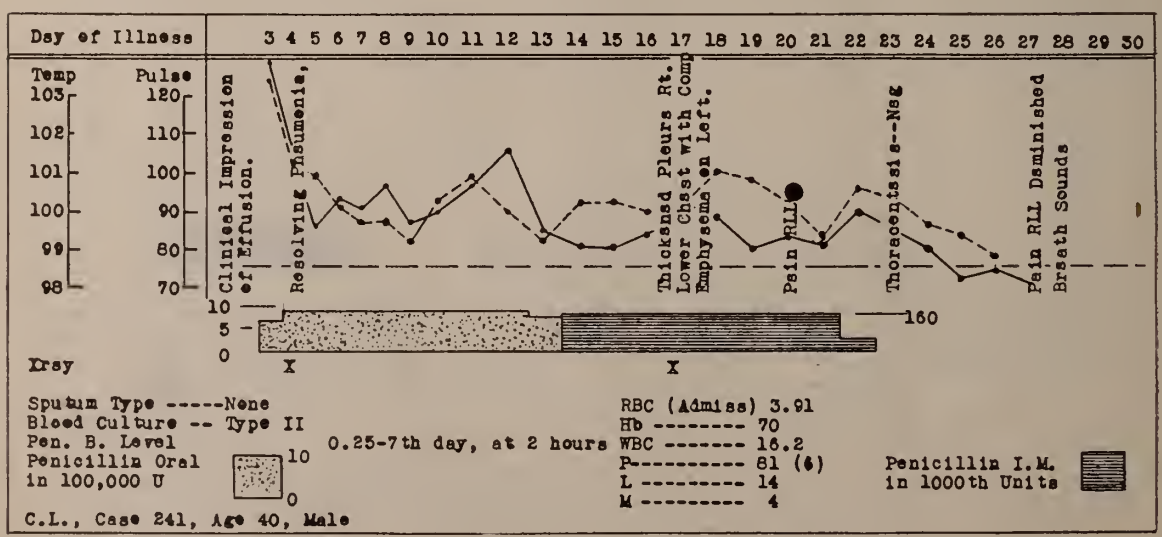


equal to it. Chart II and III illustrate the expected response, in a typical response group.

Chart IV indicates the one death in the typed pneumococcus series. Male heavy alcoholic with type II bacteremia, 55 years of age, was admitted eight days after onset of illness with a right middle lobe consolidation, severe headache and neck rigidity pronounced enough to indicate a spinal puncture on entrance. This proved negative but clinical symptoms forced a repeated puncture which showed meningitis. This did not respond to treatment. As this series includes complicated pneumonias as admitted, this patient with the mortality is part of the statistical compilation presented in this study.

Untoward Effects of Penicillin.—Parenteral Penicillin has been reported giving 5.7 and 5.5 percent skin reactions. Our experience in the oral method administration previously reported was 3.8 percent. However, using the pure crystalline potassium preparation in this series of pneumonia patients one mild erythema reaction was noted. Urticaria did not develop. Skin reactions to crude penicillin are frequent. The purity of the drug probably accounts for the infrequency of untoward effects.

Chart VII



COMMENT AND DISCUSSION

The assay and dosage studies by Hoffman and Volini already referred to several times indicate blood level determinations of penicillin. The lower concentrations of penicillin which are attained in the blood and the urine following the oral use, as compared to the parenteral method is probably mainly the result of a defect in absorption. It is not due to penicillin lost by acid destruction. Clinical employment of the oral method requires about five times the parenteral dosage as our assay studies show. Blood levels averages of 0.093 unit per c.c. are demonstrated in this series at the third hour. Such levels should be effective against infections by most of the organisms regarded as sensitive to penicillin. Pneumococci are inhibited at 0.03 unit per c.c. levels. Frequently 0.01 units per c.c. suffices. The anticipated favorable response not occurring in a 48 hour period of oral administration demands a reappraisal on the following postulates:

1. Blood level inadequate because of absorption defects or other reasons.
2. Penicillin insensitive organism or penicillin insensitive strain of an ordinarily sensitive organism.
3. Complications such as effusion empyema, meningitis, abscess.
4. Complicating diseases such as produced by additional micro-organisms but which are insensitive to penicillin.
5. Complicating diseases which disrupt the immunological mechanisms which are necessary to recovery from infectious disease.

The therapeutic course must be charted then accordingly, guided by the new evidence, obtained through the reappraisal. This may be accomplished by increasing the dosage of the oral drug, by administering penicillin parenterally or locally or topically by surgical drainage, by adding other forms of specific or non specific therapy. The in vitro sensitivity testing of the invading organism to penicillin may be valuable information for determining the course of procedure.

SUMMARY AND CONCLUSIONS

1. This report comprises a study of 48 pneumonia patients treated with oral penicillin.
2. The dosage consisted of 200,000 units initially on admission to the hospital followed by 100,000 units at each clock hour of 3, 6, 9, 12 day and night.
3. Adequate therapeutic levels against pneumococci were demonstrated by penicillin assay of the blood using the oral dosage described.
4. No attention was paid to the time relationship of penicillin administration to food intake.
5. Specific buffering agents were not employed.
6. There were three deaths in this series, 6.3% in all and in the typed pneumococcic group 7.6%. This is much less than in studies we have reported for sulfathiazole, sulfadiazine and sulfamerazine therapy. This would indicate that oral penicillin as employed in this series is a better therapeutic agent than the sufonamides.
7. The major deterrent to oral penicillin therapy in the indicated dosage is the cost of this medication. Compared to sulfadiazine it requires five times the financial outlay. Cost comparison with parenteral penicillin is difficult to estimate because cost of services must be included in the latter computation.
8. The severity of the infection has been found to have slight relation to the dosage of penicillin required providing therapeutic blood levels are maintained. The sensitivity of the pneumococcus to pencillin is marked and is the determining factor in dosage. Bacteremia responds to the dosages advised. Complications such as meningitis, empyema, acute bacterial endocarditis are refractory to almost any dosage and usually require local or topical administration to be of benefit.
9. The temperature returns to normal in the primary atypical pneumonias or pneumonias of undetermined etiology parallel the response given by pneumococcic etiology on the same therapy. This suggests that these atypical pneumonias should be given similar therapy to those of pneumococcic etiology.
10. The treatment of pneumonia by oral penicillin in the dosage and by the methods described proved as satisfactory if not superior to chemotherapy and almost the equal of parenteral penicillin treatment.

1511 North Dearborn Parkway

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Routine Technic of a Typical Rhinoplasty

Samuel Fomon, M.D. and
Victor R. Syracuse, M.D.
New York City

I. PREOPERATIVE MANAGEMENT

1. One hour before operation, administer 2 capsules (0.13Gm) nembutal.

2. Clip vibrissae with blunt-end scissors. Do not puncture vestibular skin. Scrub vestibules with green soap and water on cotton-tipped applicators. Swab with alcohol; follow with ether.

3. Anesthetize nasal fossae: Dip 3 cotton-tipped applicators in solution of equal parts 10 per cent cocain and 1:1000 adrenalin, squeeze out excess fluid, and insert as follows (Figure 1): (a) One beneath dorsum along olfactory sulcus (internal nasal nerve block). (b) One at foot of middle concha (sphenopalatine ganglion block). (c) One along floor of nose (nasopalatine and anterior palatine nerve block). Repeat procedure on opposite side.

4. Instil 2 drops of sterile castor oil into each eye. Transfer patient to operating table, with head slightly elevated on pillow.

5. Second Assistant: (a) Scrub hands. (b) Don gloves but no gown. (c) Drape head and neck of patient with sterile linen. (d) Withdraw nasal applicators. (e) Scrub face and vestibules with green soap and water on gauze sponges for 3 minutes. (f) Swab face and vestibules with alcohol, followed by ether. Avoid mucosa. (g) Remove gloves and don sterile raiment. (h) Stand by.

6. First Assistant: (a) Re-drape patient from head to foot. (b) Arrange instruments on Mayo table. (c) Take position at patient's left.

7. Operating Surgeon: (a) Take position at patient's right. (b) Pack nasal fossae with long strips of half-inch gauze, leaving vestibules clear. (Figure 2).

II. OPERATIVE MANAGEMENT

A. Anesthetization of External Nasal Pyramid.

1. Elevate left ala with rake retractor. Locate plica nasi (anatomic shelf formed by lower margin of upper lateral cartilage). Place 5 cm. 24-gauge needle at center of upper surface of this ledge (Figure 3). Under control of fingers advance needle in plane above perichondrium and periosteum to nasal root. Discharge 0.5 cc. of solution—1.5 per cent monocain to which has been added 10 drops to the ounce 1:1000 adrenalin—(infratrochlear nerve block). Withdraw needle to junction of nasal bone and upper lateral cartilage and deposit another 0.5 cc. (external

Presented before the Section on Eye, Ear, Nose and Throat, 107th Annual Meeting, Illinois State Medical Society, Chicago, May 12-14, 1947.

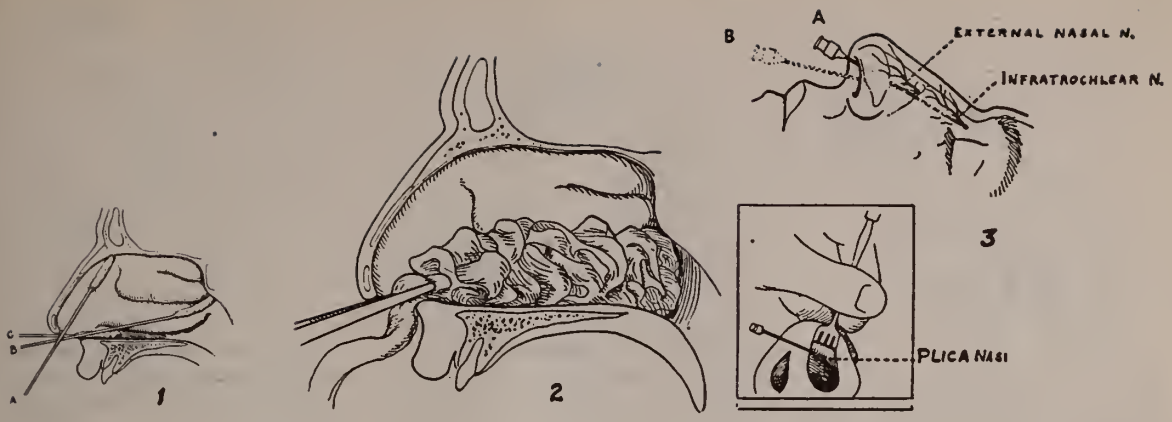


Figure 1 — Nasal mucosa anesthetized by direct block. A, Internal nasal nerve block. B, Sphenopalatine block. C, Nasopalatine and anterior palatine block.

Figure 2 — Gauze strip introduced to prevent escape of blood into nasopharynx.

Figure 3 — Infratrochlear and external nasal block. Five-centimeter 24-gauge needle introduced into plica nasi. A, Needle advanced to nasal root and 0.5 cc. of solution discharged. B, Needle withdrawn to caudal margin of nasal bone and 0.5 cc. discharged.

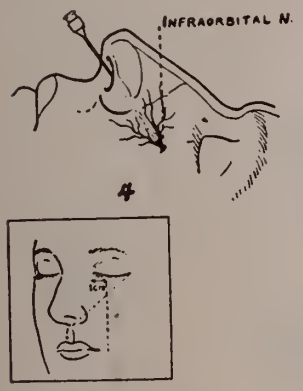
nasal nerve block). (Figure 3). Repeat procedure on opposite side.

2. Change to 4 cm. 24-gauge needle. Introduce intranasally at outermost margin of pyriform opening. Carry to point at imaginary intersection of (a) vertical line drawn 1 cm lateral to inner canthus, and (b) oblique line from columella to lateral canthus. (Figure 4). Discharge 0.5 cc. of solution as needle is withdrawn (infraorbital nerve block). Repeat on opposite side.

3. Change to 2½ cm. 24-gauge.needle. Introduce at anterior nasal spine. Advance along floor of nose to incisive foramen. On withdrawal introduce 0.5 cc. of solution (nasopalatine and anterior palatine nerve block) (Figure 5). Repeat on opposite side.

B. Uncovering of Nasal Framework.

1. Elevate left ala, using rake retractor. Locate plica nasi. With Bard-Parker No. 11 knife incise aponeurosis connecting upper and lower lateral cartilages. Begin incision at center of



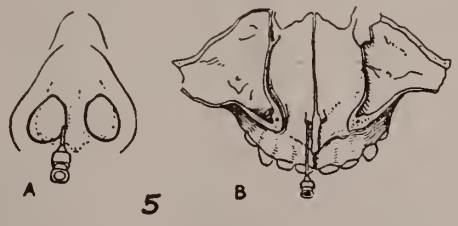




Figure 4 — Infraorbital block. Four-centimeter 24-gauge needle introduced at outermost margin of pyriform opening, carried to intersection shown in insert, and 0.5 cc. of solution discharged.

Figure 5 — Anterior palatine and nasopalatine block. Two and one-half centimeter 24-gauge needle introduced at anterior nasal spine, advanced along floor to incisive foramen, and 0.5 cc. of solution discharged.

Figure 6 — Plica nasi exposed and aponeurosis connecting upper and lower lateral cartilages incised with Bard Parker No. 11 knife.

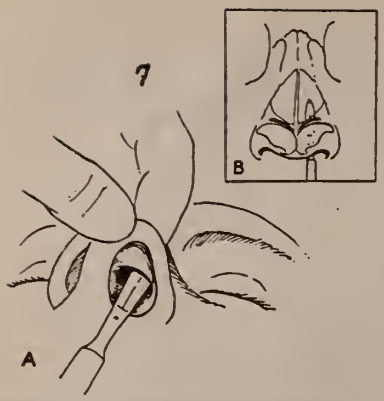


Figure 7 — Soft structures overlying upper cartilaginous vault elevated. A, Daubie-edged knife introduced into vestibular incision and carried to caudal margin of nasal bone in plane above perichandrium. B, Ventral view.

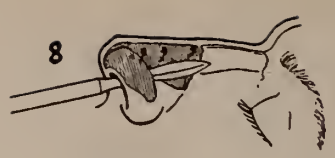


Figure 8 — Knife swept from side to side, separating structures for distance equal to width of blade.

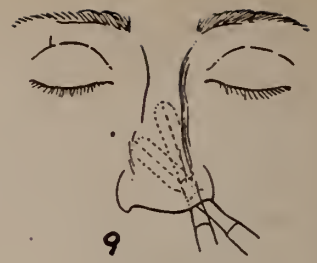


Figure 9 — Separation of soft structures continued over dorsum with blunt, curved, double-edged knife.

plica and extend it ventrally to septum. (Figure 6). Make similar incision on opposite side.

2. Into left incision introduce straight pointed double-edged Joseph knife. (Figure 7). Carry to a point 1-2 mm. above caudal margin of nasal bone in plane immediately above perichondrium of upper lateral cartilage. Sweep knife from side to side, separating structures for distance equal to width of blade, and withdraw. (Figure 8). Repeat procedure on right side.

3. Through left incision introduce Fomon's curved double-edged blunt-tipped knife, and continue separation over dorsum in same plane as before. (Figure 9). Repeat on opposite side.

4. Through left incision introduce MacKenty elevator and incise periosteum 1-2 mm. above caudal rim of nasal bone. Substitute Joseph's periosteal elevator and elevate periosteum over dorsum up to nasofrontal suture. Do not tear periosteum. (Figure 10). Repeat on opposite side. Soft tissues overlying ventral and lateral nasal walls are thus freed.

5. Introduce button-end knife through left incision and advance to nasofrontal suture, knife hugging perichondrium of upper lateral cartilage and passing beneath periosteum of nasal bone. Sweep obliquely downward across dorsum

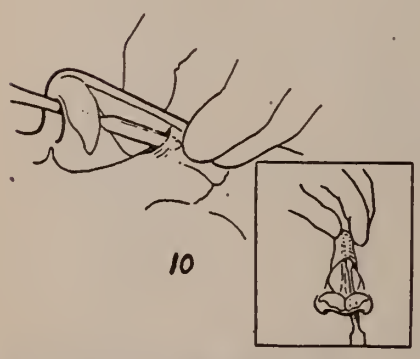


Figure 10 — Periosteum over nasal bone elevated.

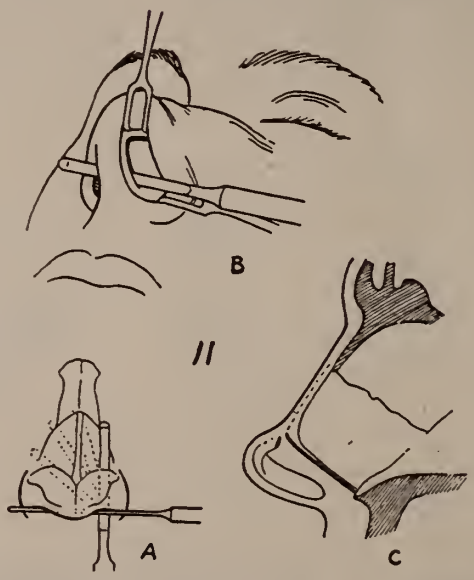


Figure 11 — Caudal exposure of nasal pyramid. A, Button-end knife introduced, advanced to nasofrontal suture, swept obliquely downward until tip appears through opposite intercartilaginous incision. B, Membranous septum cut through. C, Line of separation.

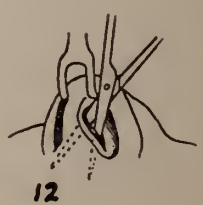


Figure 12 — Completion of caudal exposure. Membranous septum straddled by Maya scissars and structures divided to nasal spine.

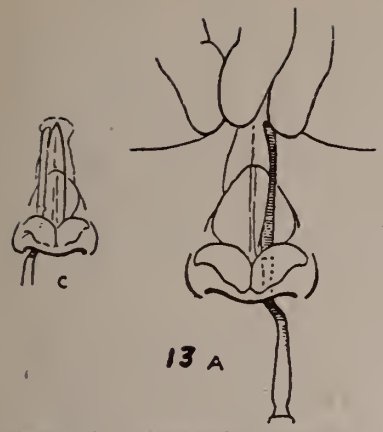


Figure 13 — Removal of hump. A, Left saw placed against bone at level to attain desired profile angle. B, Left nasal bone and perpendicular plate of ethmoid cut through. Niche made in right nasal bone. C, Saw-cut through right nasal bone completed.

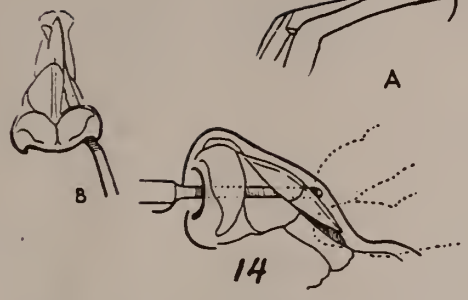


Figure 14 — Cartilaginous hump cut through with button-end knife.

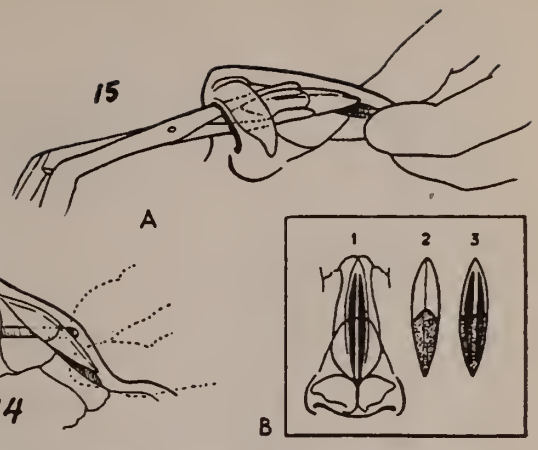


Figure 15 — A, Hump extracted. B-1, Appearance of dorsum after removal of hump. B-2, Ectal surface of hump. B-3, Ental surface.

until tip appears through intercartilaginous incision in right vestibule (Figure 11A).

6. Without altering plane of knife (which now transfixes nose), cut to caudal end of septum.

7. Turn knife at a right angle and, with blade hugging caudal margin of septal cartilage, divide membranous septum through 2/3 of its extent. (Figure 11 B and C).

8. Take position at head of patient. With straight Mayo scissors held perpendicular to nasal spine, straddle membranous septum, points of scissors being made to lie on nasal spine. (Figure 12). With one snip of scissors complete separation.

C. *Removal of Hump*

1. Retract left ala. Locate incision in plica nasi. Introduce left bayonet saw.

2. With teeth directed dorsally, advance instrument beneath periosteum to nasofrontal suture. Turn teeth of saw at a right angle to nasal wall and place against bone at level to attain desired profile angle, previously determined by cast, photographic, and biometric analysis.

3. Check position of saw with analyzed photographs and cast, held in same position as patient's head.

4. With fingers of left hand fix apex of saw. With handle of saw held in right hand, wrist and elbow rigid, saw through nasal bone, using shoulder joint as fulcrum. (Figure 13A). When bone has been cut through, indicated by a loss of resistance, shift handle obliquely and continue sawing through perpendicular plate of ethmoid. When this has been accomplished, tip of saw will be felt at nasal root on opposite side. (Figure 13B).

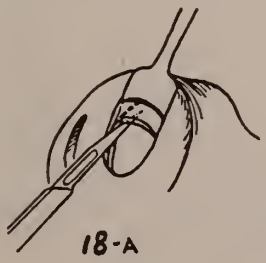
5. Remove left saw.





Figure 16 — Bony margins polished with rasp.

Figure 17 — Cartilaginous margins pared with angulated knife.



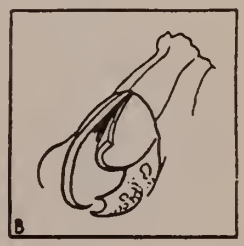


Figure 18 — A, Angle between septum and upper lateral cartilage cut through with Bard Parker No. 11, angulated speculum serving as guard. B, Appearance of cartilages after division.

6. Retract right ala and introduce right bayonet saw, same as left. Fix point of saw at root in niche made by left saw.

7. Place saw against right nasal bone at same level as saw cut on left side. Check level by palpating left groove. Saw through bone. (Figure 13C).

8. Palpation discloses that bony hump is now free and cartilaginous hump fixed.

9. Retract left nostril. Introduce short button-end knife into vestibular incision. Insert blade beneath severed bony hump.

10. Draw knife down, cutting cartilaginous portion of hump away from upper lateral and septal cartilages, maintaining same level throughout, until instrument falls free into tranfixion incision. (Figure 14).

11. Extract hump with hemostat or Knight forceps. (Figure 15).

12. Palpate nasal dorsum. Note central ridge formed by perpendicular plate of ethmoid and septal cartilage, and two lateral ridges composed of frontal processes of maxillae and upper lateral cartilages. (Figure 15).

13. Examine hump for symmetry. In the event of bony asymmetry, pass Fomon rasp through left vestibular incision, and file until plane of dorsum is even (Figure 16). If sides of cartilaginous hump are asymmetrical, introduce right-angled cartilage knife and pare projecting side until it equals its fellow (Figure 17).

14. Remove bone dust, spicules, and other debris with sweeper.

15. Finally, introduce angulated nasal speculum. Throw light into nose and inspect dorsum.

D. Shortening of Nose

Shortening of Median Wall (Septum)

1. Insert 2-pronged retractor into left nostril and draw soft tissues to one side, exposing septum and upper lateral cartilages.

2. Inspect septum and note flare of upper lateral cartilages.

3. Remove retractor and introduce angulated speculum between soft tissues and cartilaginous vault. Use this instrument as a guard.

4. With a No. 11 Bard-Parker knife separate septum from upper lateral cartilage, blade cutting up on speculum. (Figure 18A).

5. Repeat on opposite side. Inspection will disclose 3 structures—the septum in the middle and the upper lateral cartilages on either side. (Figure 18B).

6. Introduce retractor into left nostril and draw soft tissues aside to expose septal cartilage.

7. Take position behind patient. Grasp caudal end of septal cartilage with fixation forceps. With straight Mayo scissors held perpendicularly and straddling septum, excise triangle with base on dorsum and apex at anterior nasal spine. Size of base will govern amount of shortening, as previously determined by analysis. (Figure 19).

Shortening of Lateral Walls (Upper Lateral Cartilages).

Before shortening the lateral walls (upper lateral cartilages) is is necessary to reapproximate the columella to the septum in order to gauge the proper amount to be excised. (Figure 20).

1. Pass straight cutting needle armed with heavy silk (No. 1 or No. 2) through full thickness of ventro-caudal (antero-inferior) angle of septal cartilage (perichondrium, cartilage, perichondrium). Continue suture by passing needle through full thickness of columella (vestibular skin, mesial crura, vestibular skin) at junction of anterior and middle thirds.

2. Tie first loop of knot and exert tension on ends. Note gradual forward projection of lobule.

3. When proper projection has been attained, as determined by preoperative analysis, complete tie.

4. Using same needle and suture, reinforce orthopedic stitch by passing another suture through full thickness of posterior 1/3 of septum and corresponding part of columella.

5. Retract ala with rake retractor and note projection of upper lateral cartilage into vestibule.

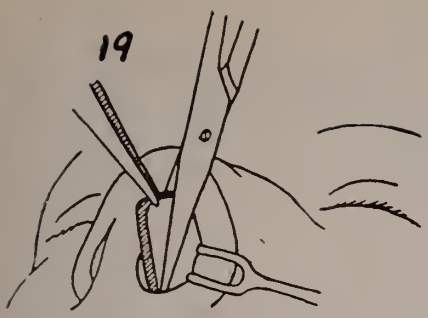
6. Grasp protruding portion with rat-tooth forceps, but exert no traction. With angulated scissors excise projecting part flush with incision. (Figure 21).

7. Repeat on opposite side.

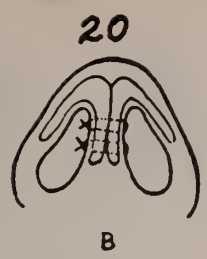
E. Narrowing of Nose

Flatness of dorsum following hump removal is eliminated by shifting of lateral walls to midline. This is accomplished by lateral osteotomies through frontal processes of maxillae.

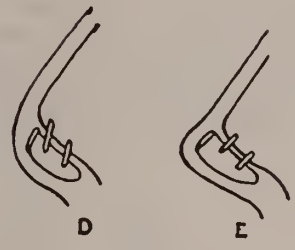
Lateral Osteotomy.—1. Retract left ala. Locate lateral margin of apertura pyriformis (point below alar-facial junction). With a No. 11 Bard-Parker knife incise overlying mucosa down to bone. (Figure 22).











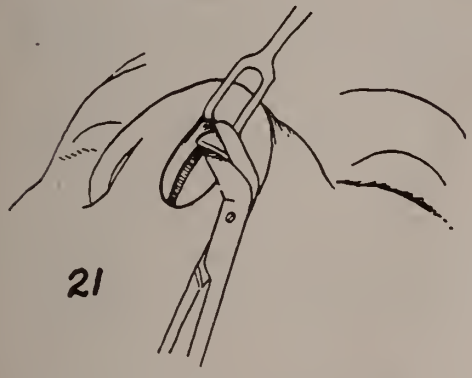
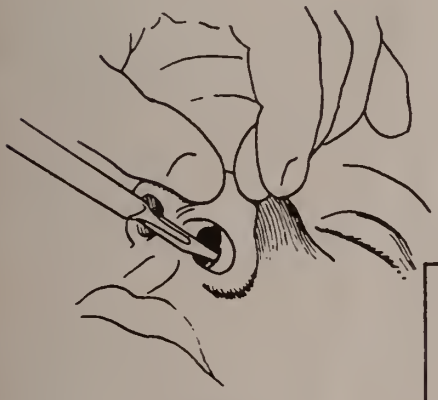


Figure 19 — Removal of triangle from caudal margin of septum. Size of base will govern amount of shortening.

Figure 20 — A, Approximation of columella to shortened septum with 2 oblique silk sutures. B and C, Sutures tied, bringing lobule forward. D and E, Clarification of method.

Figure 21 — Shortening of upper lateral cartilage. Protruding portion of upper lateral excised flush with incision.

Figure 22 — Lateral osteotomy. A, Mucosa overlying lateral margin of apertura pyriformis incised with No. 11 Bard Parker. B, Line of incision.



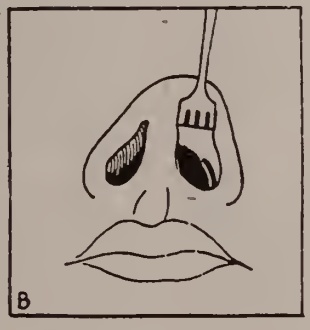
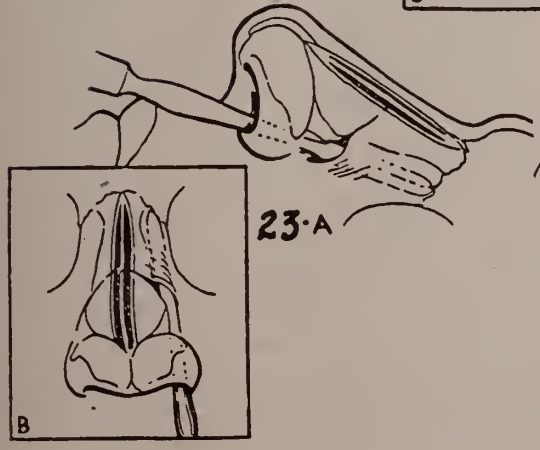
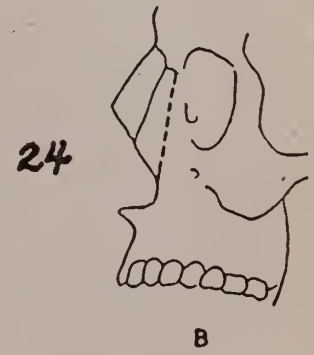


Figure 23 — A, Elevator introduced beneath periosteum and tissues raised en masse over line of proposed saw cut. B, Ventral view.

Figure 24 — A, Grooved director introduced into incision along margin of pyriform opening. B, Line of saw cut indicated by dotted line.







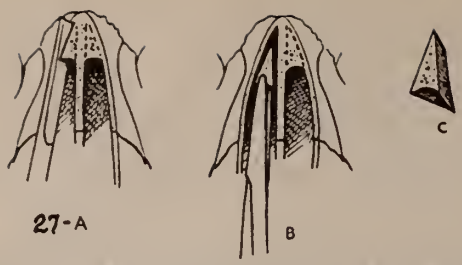


Figure 25 — A, Saw, guided by grooved director, introduced into periosteol pocket. B, Sow engoged along nosofociol groove, opex midwoy between inner canthus ond nosion and base resting on outermost morgin of pyrlform opening. Bone cut 2/3 through.

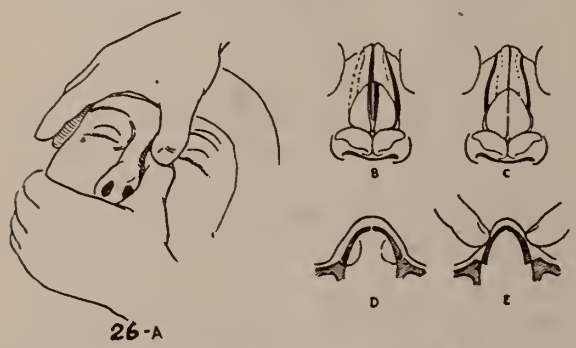


Figure 26 — Infrocturing of nasal bones. A, Nasal bones brought to median line by thumb pressure. B, One woil shifted inward. C, Appearonce after Infracture of both wolls. D ond E, Sectional views.

2. Introduce MacKenty elevator beneath periosteum and raise overlying tissues en masse from nasofacial groove to point midway between nasion and inner canthus. (Figure 23). Extent of elevation should be no more than to comfortably admit saw.

3. Introduce grooved director into incision made along margin of pyriform opening (Figure 24). Using this as a guide, pass left right-angled saw into periosteal pocket, teeth directed downward (Figure 25A). Remove director. Turn saw so that teeth lie at right angles to bone. Manipulate instrument until it falls into nasofacial groove, apex lying at a point just below and medial to inner canthus, and base at outermost margin of pyriform process (Figure 25-B). Place fingers of left hand over apex of saw to fix it and protect inner canthus.

4. With several up and down strokes cut through 2/3 thickness of bone. Under no circumstances cut all the way through.

5. Repeat procedure on right side.

6. Take position on left side of patient. Place pad of gauze over left nasal wall. Brace both

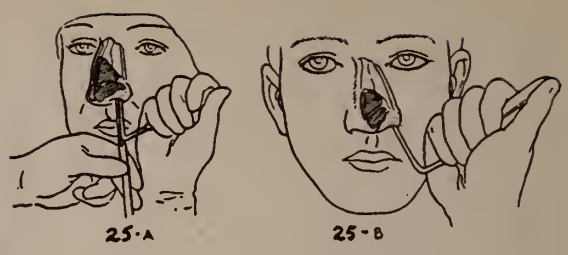


Figure 27 — Removol of bony wedge. A, Loteral woll of bony wedge cut through by guorded chisel held obliquely. Dotted lines indicote course of chisel cuts. B, Wedge removed. C, Appearonce of wedge.

thumbs over gauze, spread fingers over opposite zygoma, and with moderate pressure force nasal walls to midline. (Figure 26). Repeat on opposite side. Complete fracture will be evidenced by a short, decisive snap. If greenstick, the sound will be less distinct and the bones less movable, with a tendency to spring back into place.

7. Introduce Walsham forceps and rotate left nasal wall into nasal fossa. Repeat on opposite side. This will overcome any tendency to a subsequent broadening of the arch which might arise in the process of osteogenesis.

If the excessive width includes the solid block of bone at the nasal root, bony wedges must be removed from this area prior to the lateral osteotomy, to make room for shifting lateral walls to midline.

Removal of Bony Wedge.—1. Engage Fomon guarded chisel at junction of solid block of bone and frontal process of maxilla. With few taps of mallet on chisel held obliquely, cut through bone to nasofrontal articulation. (Figure 27A).

2. Engage chisel at junction of solid block of bone and perpendicular plate of ethmoid. Cut through obliquely so that chisel cuts meet beneath wedge.

3. Extract bony wedge with stout hemostat. (Figure 27 B and C).

4. Repeat on opposite side.

F. Modelling of Lobule

Notice that the lobule, even if in proper relationship to the balance of the nose before operation, is now relatively too wide and too projecting and must be modelled if it is to harmonize with the reconstructed osseous and upper cartilaginous vault.

1. Retract left ala and with No. 15 Bard-Parker knife make semicircular incision through

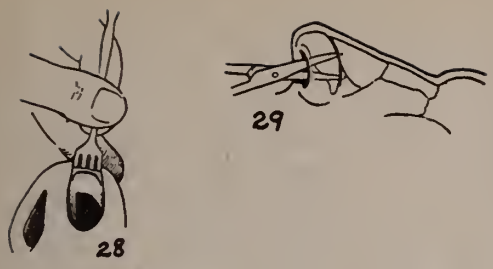


Figure 28 — Modelling of lower lateral cartilages. Circumferential incision along caudal margin of lower lateral cartilage.

Figure 29 — Overlying structures separated in plane immediately above perichondrium. Blunt-end scissors passed from circumferential incision to original intercartilaginous incision.

vestibular skin along caudal (lower) margin of lower lateral cartilage (Figure 28).

2. Introduce blunt-end scissors between lower lateral cartilage and overlying structures, hugging perichondrial plane (Figure 29).

3. Gradually separate tissues in upward (cephalad) direction until instrument falls into initial incision in plica nasi.

4. Carry scissors obliquely and gradually separate overlying skin until angle of lower lateral cartilage is completely freed.

5. Repeat procedure on opposite side, so that separation over entire lobule is complete.

6. With dural hook placed exactly beneath angle of left lower lateral cartilage, draw cartilage out of nostril. Under this double-edged pedicled vestibular skin-cartilage flap pass Neivert grooved director (Figure 30-A).

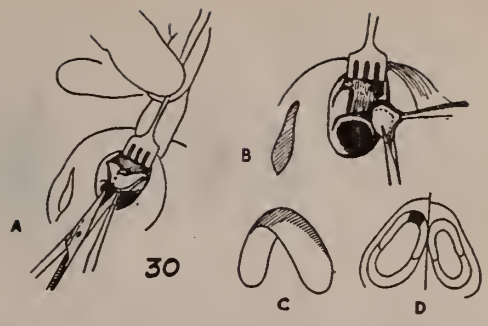


Figure 30 — A, Liberated lower lateral cartilage withdrawn as double-pedicled flap and supported by strabismus hook. Dots indicate line of section. B, Lateral flap drawn out and trimmed along dotted line. C, Amount of tissue to be removed indicated by shaded area. D, Effect of cartilaginous excision on projection and width of tip.

7. Deliver right lower lateral cartilage in like manner.

8. Divide cartilages at angles.

9. Steady left lateral flap (lateral crus) with dural hook, and with fine scissors pare cephalic margin of cartilage sufficiently to reduct bulbousness (Figure 30 B, C, D). De-epithelize free end of cartilage for distance of 3-4 mm. Repeat on opposite side. (Figure 31).

10. To reduce projection, draw out mesial crura with dural hook, remove intercrural soft tissue. Trim cartilages desired amount. Approximate mesial crura with 5-0 catgut. Finally, pinch cartilages into position so that de-epithelized lateral crura form inverted V over mesial crura. This approximation serves not only to narrow tip, but also gives it a more natural appearance by projecting it slightly beyond the dorsal line.

G. *Modelling of Columella*

1. Through transfixion incision, excise excess

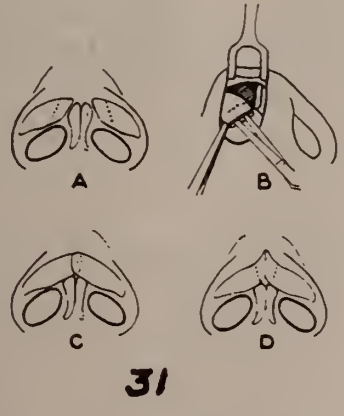


Figure 31 — A, De-epithelized surfaces of lateral crura overlapped. B, De-epithelized surfaces brought together over mesial crura in form of inverted V.

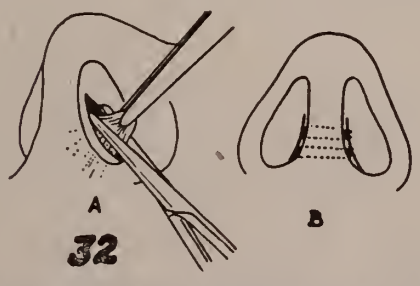


Figure 32 — Modelling of columella. A, Excess subcutaneous tissue and cartilage excised from columella. B, Mesial crura approximated with black silk.

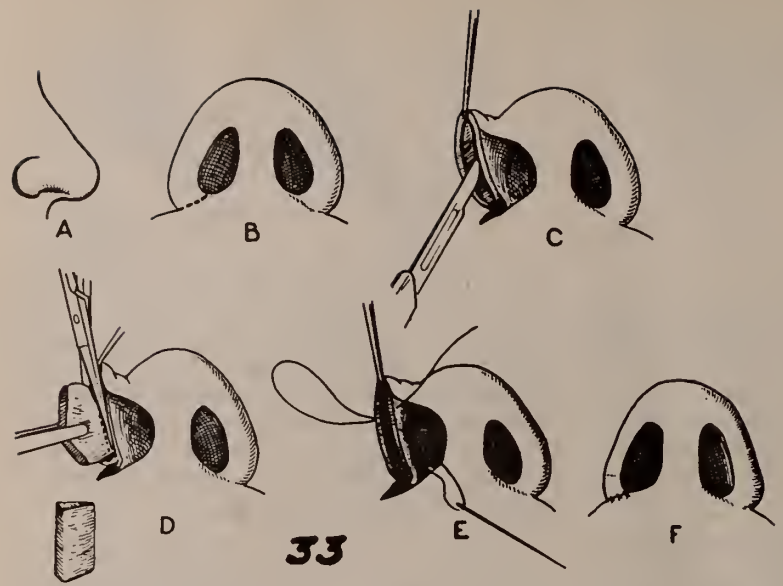


Figure 33 — Reduction of thick aloe. A-B, Alae seporated from cheek along alarfocial groove. C, Shorp dlssection of fotty pad between skln layers. D, Resection of fatty wedge. E, Skin edges brought together with silk suture, so passed that loop dlsappears beneoth skin surface. F, Alae reattached.

subcutaneous tissue and cartilage from columella. (Figure 32).

2. Approximate mesial crura with black silk.

H. *Modelling of Alae*

If too thick. (Figure 33) 1. Separate alae from cheek along alarfacial groove.

2. Dissect out fatty pad between external and vestibular skin.

3. Approximate raw surfaces with through and through sutures, tied on vestibular surface. Pass in such a manner that loop is lost beneath skin surface.

4. Repeat on opposite side.

If too long. (Figure 34) 1. Separate ala from cheek along alarfacial sulcus.

2. Force alar rim beneath mesial margin of wound until proper configuration is obtained.

3. Mark out line of contact and remove excess tissue.

4. Reattach ala with atraumatic sutures.

5. Repeat on opposite side.

I. *Modelling of Base*

If too wide. 1. Separate ala along alarfacial junction.

2. Force alar rim over base until proper configuration is obtained.

3. Mark line of contact and excise excess tissue in form of wedge.

4. Reattach ala to base.

5. Repeat on opposite side.

Conclusion of Operation

1. Withdraw nasal packs.

2. Remove debris with sweeper.

3. Make final inspection of result. Observe (a) from above—width and curve of dorsum and shape of lobule; (b) from sides—projection, length and profile outline; (c) from in back of patient—relation of nasal elements to midline, especially symmetry of lower cartilaginous vault; (d) from below—size, shape and symmetry of nares. This is best accomplished by viewing through sterilized metal mirror held in front of nostril.

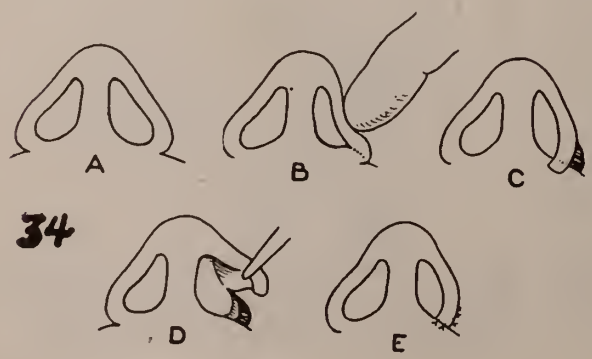


Figure 34 — Reduction of elongoted aloe. A, Long aloe. B, Aloe pressed ogoinst cheek to determine alarfacial junction. C, Ala forced beneoth medial margln of wound to secure proper configurotion, and excess tissue morked out. D, Excess tlssue removed. E, Reduced ala reattached.

4. Correct any minor defects.

Dressing

1. Immobilize flaps of lower lateral cartilages with loose packing of vaseline gauze.
2. Paint skin surface with compound tincture of benzoin.
3. Strap nose with adhesive tape.
4. Apply stent dressing: (a) Cut flannel in form of butterfly and cover with softened stent. (b) Mold flannel-lined stent to nose. (c) Hold in place until it hardens. (d) Fix by strips of half-inch adhesive running obliquely from forehead to cheek and horizontally from cheek to cheek. Strap small pad of gauze over base of nose to absorb any oozing.

POST OPERATIVE MANAGEMENT

First 48 hours.

1. Patient flat on back.
2. Sand bags to either side of head.
3. Ice packs to eyes.
4. Semisolid diet for first 24 hours.
5. No visitors.
6. Advise against talking, laughing, etc.
7. Hands restrained at night.
8. For discomfort or restlessness, luminal 0.065-0.13 Gm., codein 0.016 Gm., or aspirin 0.3—0.6 Gm.
9. Visit patient twice daily. Note temperature, pulse and respiration at each visit. A rise of temperature of 1 degree which gradually falls within first 48 hours is of no consequence.

After 48 hours

1. Grant bathroom privileges and allow patient to walk about during day.
2. Remove atraumatic sutures (if used) on 3rd day.
3. Remove splint on 4th day. With cotton-tipped applicator dipped in benzene gradually separate adhesive. Carefully lift splint from nose. (Leave adhesive in place until 6th or 7th day).
4. Instil a few drops of hydrogen peroxide into each nostril and gently withdraw vaseline packs. Guard against pulling as it may displace the flaps. If gauze sticks despite use of peroxide, leave in for another day.
5. Remove intranasal sutures on 6th or 7th day.

The Role of Developmental Diagnosis in Pediatrics

Catherine S. Amatruda, M.D.
New Haven, Conn.

The medical care of children in the United States has made enormous strides in the past few decades. With the advent of modern principles of infant feeding, and of knowledge of mineral and vitamine requirements, infant mortality has been tremendously reduced. Serious malnutrition, rickets and scurvy are rapidly becoming medical rarities. Immunizations are controlling the communicable diseases and the antibiotics have given us a new mastery over infections. Illness still occurs in childhood, but treatment is no longer merely palliative; it is now active and specific and it is steadily becoming more and more successful. The American child is sturdier, better nourished and healthier by far than were his predecessors and than are most of his contemporaries in other parts of the world.

Lest we become too self-satisfied with this success story, it is well to recall that there still remains much to be done. We cannot claim that our children are sounder mentally, of better emotional stability and stamina than their antecedents, or that we are turning out fewer neurotics, psychopaths, mental defectives, or physically and socially handicapped individuals than in the past. Some would probably say that there are

From the Clinic of Child Development, Yale University School of Medicine, New Haven.

Presented before the 108th annual meeting, Illinois State Medical Society, May 12, 1948.

more mental and emotional deviates now than ever before. Actually, a comparative statement of any validity would be difficult to make. It is, however, certainly true that we are steadily increasing our facilities for the care and treatment of the mentally ill, the mentally defective and the criminal, or socially ill. We have in fact reached the point where we are beginning to think in terms of prevention, as well as of treatment.

And as soon as we begin to think in terms of prevention, we have to go back to infancy and early childhood. How soon can we diagnose neurological disorders, behavior disorders, and mental deficiency; what can we find out about causative factors; what part do environmental factors play? Can we identify the potential neurotic, the potential psychopath, the potential delinquent, the potential criminal? Can we so guide and protect him that his inadequacies will remain only potential, or can we in some way make him an adequate individual? What part do disease and injury play and what can we do to lessen the possibilities and the effects of disease and injury?

Any preventive program must ask these questions and we cannot assume we have the answers without investigation. We cannot assume, for instance, that all abnormalities and inadequacies are acquired, though we see many that are. Such an assumption leads to absurdities, such as prolonged psychotherapy of the mentally defective child whose behavior defects are mistakenly assumed to be due to emotional conflicts. Nor can we assume that all abnormalities and inadequacies are inborn and inherent in the individual, though we see some that would certainly seem to be so. Such an assumption leads to a fatalistic, defeatist attitude that is wholly unwarranted when we stop to consider the gaps in our knowledge. Recent recognition of the effects of maternal rubella on the fetus in the early weeks of gestation, has made it apparent that not all congenital abnormalities are due to defective genes; some are acquired. Medical science is based on facts, and assumptions are not facts. We must go on asking questions and looking for answers.

In our investigations into some of these questions at The Clinic of Child Development at Yale University, we have begun with the problems of diagnosis. We have developed a technic of examining the infant and young child which we call *developmental diagnosis,* much as physical diagnosis is based on the standard physical examination; it is used in conjunction with, or as a supplement to the physical examination.

Developmental diagnosis is an inclusive term: it includes first, diagnosis of the maturity status of the child, — how well he is developing for his age, and what his developmental potentialities are; second, neurological diagnosis of the integrity of the central nervous system, exposing defects and damage; third, diagnosis of the personality structure and emotional stability of the child in relation to his life experiences; and fourth, evaluation of his life experiences including the important parent-child relationship. The developmental examination is an examination of the childs' behavior, in terms of his age, his physical equipment for behavior, his personality make-up and his life situation. To the child the examination is a play period, to the physician it is a formal diagnostic procedure with a valuable yield in his knowledge of his patient.

The examination assays the four major fields of behavior; motor behavior, language behavior, adaptive behavior and personal-social behavior. In the motor field we observe, depending on the age of the patient, how the infant holds his head, his ability sit, to reach, grasp and manipulate, to creep, walk and run. And we determine not only whether these abilities are normally developed for his age but also whether they are normally performed. The simple act of grasping a small cube, for example, is achieved on contact, that is, if the hand happens to fall on the cube, at 20 weeks of age in the normal infant. The grasp is precarious, the hand grips in a paw-like manner with the ulnar side of the hand. At 24 weeks of age the infant grasps on sight; he sees the cube, brings both hands to it, and grasps it with one hand, gripping it in a paw-like manner with the whole hand. At 28 weeks of age, he approaches the cube with one hand, suppressing the movement of the other arm, and grasps it in a paw-like manner with the radial side of the hand. At 36 weeks of age he grasps it with his radial fingers, the thumb opposed. This example serves to illustrate the developmental process in the fine motor field, how it can be traced and followed, how it can be related to age, and how the normal patterns can be identified. It follows that disorders affecting

motor power, muscle tonus, and motor coordination are equally readily identified. Abnormal posturings and movements take on neurological significance.

Language development is also investigated in the course of the developmental examination, — smiling, cooing, laughing, syllabic vocalization, jargon, words, sentences, and comprehension of gestured cues and verbal directions of graded complexity. Language behavior also has a developmental patterning closely identified with age. An early differential diagnosis between the retarded child with concomitant retarded speech development, and the deaf child who is failing to develop speech is not difficult to make. Speech defects due to tensions and pressures are differentiated from those due to organic causes, which will have impaired coordinations of the muscles involving speech and other evidences, perhaps very slight, of neuromotor disability.

In the developmental examination we also observe the child's abilities in the adaptive field of behavior, his manner of adapting to objects and problems in his environment. Does he simply stare at objects, can he grasp a proffered toy, does he play with his hands, does he combine two playthings, put objects in and out of a container, build, copy, do play-tasks of graded complexity? The normality and relevance of his interests and exploitations are appraised and evaluated, always in terms of his age. And the exploitive behavior of the normal child, even in infancy, "makes sense," with consistent evidences of relevant interest and relevant sequences of interest. The child who stares into space, wanders about, diddles aimlessly, and so forth, is displaying serious symptoms that require diagnosis.

We also appraise the development of the personal-social field of behavior, by which we mean the child's personal responses to other people and to the culture in which he lives. Does he recognize his bottle, discriminate strangers, wave goodbye, drink from a cup, ask for the toilet, play cooperatively with other children? Does he want to do things for himself, does he want to "help"?

In each of the four behavior fields, we have cited examples of progressively more mature behavior, to show in brief what is meant by the progressions of behavior, of behavior development. These progressions are determined by maturation and constitute the basic process of growth. The normal child goes through the process of growth in a lawful, orderly manner, moving from simple to more complex behaviors, to still more complex behaviors, integrating and incorporating his abilities as he goes along. Sitting before standing, standing before walking, syllables before words, words before sentences.

The examination is not difficult to administer, as most children are extraordinarily open to approach. Put the child at his ease, then offer him a toy and he will exploit it with all his maturity. Put a toy beyond his reach and he will use his locomotor capacities to the full to obtain it, vocalizing his protests and his satisfactions. In fact, it is the child's accessibility and naivete that enable us to assess many factors in his personality make-up. We observe how he makes his adjustment to the examination situation, which is, I should explain, so planned and devised that it is normally an easy and pleasant experience for the child. We note whether he is inhibited, anxious or fearful; whether his adjustment is facile or accrues very slowly; whether he clings to his mother or goes too readily to the examiner. Perhaps his emotional responses are unpredictable, with outbursts of silly laughter. Or he may be the normal well-adjusted child who meets new situations with self-confidence, sustained interest and enjoyment. And it is surprising to discover how consistently, on repeated examinations, the same child will respond in the same way. We watch the mother, too, for evidences of detachment, coldness, rejection, over-solicitude, too close identification with her child, over-emotionality, or of normal wholesome acceptance and enjoyment.

The child's experiences too, need assessment and evaluation. We must know whether this child is in his own home, wanted and loved, or whether his home is discordant, unhappy, abusive, alcoholic. If he lives in a foster home he may be merely tolerated, or he may be an integral part of a warm family unit; perhaps he has lived in a series of foster homes, never long enough in any one to put down roots and become a part of it. Or he may have had a long hospital or institutional stay, with long monotonous days and few socializing experiences. His medical history

may have a very profound effect upon development; we may be dealing with the sequelae of some serious illness such as meningitis.

This introduction has served to describe the developmental examination, which is the tool we use in diagnosis. Its diagnostic scope and precision determine in large part its usefulness, though much depends on the experience, clinical insight and skill of the operator.

It is not possible in this brief time to describe all the conditions that are encountered in clinical practice, all the behavior deviations, all the neurological disorders. A condition in which we have been much interested, namely minimal cerebral injuries in infancy, will serve to illustrate some aspects of infant neurology.

Frank cerebral palsy with its crippling spasticity and athetosis is recognized without much difficulty. There is a recent new impetus toward improved and expanded facilities for the treatment, rehabilitation and education of this handicapped group. The child with a minimal injury, however, is usually undiagnosed or misdiagnosed. His handicaps go unrecognized or misinterpreted.

The clinical picture in the first year may be quite striking. The birth history may be entirely normal, but a history of excessive jitteriness or somnolence and of poor sucking in the neonatal period is frequently encountered. Feeding difficulties may persist for months and may be the presenting symptom. Choking and gagging are particularly prominent and are due to faulty coordinations in swallowing. Strabismus of varying degrees of severity is almost universal. A unilateral facial weakness or a generalized loss of facial tone with blanking out of facial animation is not uncommon. Head control is usually good but arm and hand posturing tend to be abnormal. Quite commonly the arms are extended laterally at shoulder level with small athetotic movements of the fingers. Prehensory approach and grasp may be very distorted and defective and may even be almost completely replaced by head reaching, or by manual touching, poking and fingering, or by foot exploitation. Sitting is commonly delayed because of the tendency to adductor spasm, which produces what we call "narrow base sitting", an untenable position for the young infant. Even slight hyperactivity of the hip extensors will displace the line of weight-bearing posterior to the buttocks, another untenable position. Tonic plantar flexion of the toes is also seen. Muscle tone may be very uneven with weakness of the upper trunk and shoulder girdle, hypertonus of the legs. Excessive startling is frequent and the deep reflexes are hyperactive.

This is the full blown picture in infancy, the picture which tends to evoke erroneous diagnoses of gross mental defect. In other infants the clinical picture is less well developed, the motor signs more subtle, and more apt to be overlooked.

These motor signs happily tend to amelioration in the second and third years. Prehensory approach and grasp make their appearance sometime between the 10th and 15th month, sitting and creeping are finally achieved. Independent walking may be delayed to beyond 20 months and tends at first to be a little stiff, awkward and propulsive. Manual skills are very variably developed; the same child may be quite skillful and adept with his fingers, but unable to feed himself because of inadequacies in the complicated coordinations required for this particular skill. Speech defects due to poor labial, lingual and pharyngeal coordinations are common and drooling may persist well into the 3rd or 4th year. Lax perioral muscles may be seen long after general facial tone is fairly good.

The tendency to resolution should be emphasized; the motor signs gradually become so subtle as to almost defy recognition by the time the child is 5 or 6. There are, however, residuals. Really good coordination is rarely achieved. This is not the material from which good athletes are developed, nor does the injured child ever become really expert in such special skills as piano playing, typing, sewing. Drawing and handwriting even in later years often furnish clues.

The intelligence, so-called, tends to be good, in spite of the very abnormal developmental course in early infancy. We do, however see an occasional retarded child with residual minimal signs. Personality disorders of varying severity are by no means uncommon. Children with minimal cerebral injuries are often explosive and obsessive. They tend to have poor emotional control with exaggerated tantrums; they sometimes have bizarre fears. In rare instances, convulsions become a serious complication.

Recognition of the underlying organic basis for the behavior abnormalities will bring about wiser and more understanding management of the

so-called behavior problems these children present. Certainly they should not be considered disciplinary problems; they should be regarded as evidences of faulty coordinations in personality development. Under sympathetic guidance and management the tendency in the personality field, as in the motor field, is toward resolution and amelioration.

A survey of 100 supposedly normal infants seen at our clinic, revealed six with evidences of minimal injury. There is no autopsy evidence to substantiate our hypothesis that an injury has been sustained. The diagnosis is presumptive; it is based on the high incidence of neonatal symptoms, the organic nature of the neurological signs in infancy, the obvious gradations into frank cerebral palsy that are seen, the normal family history and the normality of the siblings.

The Constitutional Emotional and Cultural Factors Producing Mental Deficiency

Hans Neuer, M.D.
Lincoln State School and Colony*
Lincoln

The problem of mental deficiency was formerly approached in three main avenues: by neuropathology, by eugenics, and by intelligence tests. Intelligence was assumed to be a special faculty localized in the brain cortex, and mental deficiency a disease entity due to brain pathology for which in 80% of cases hereditary, recessive factors were blamed as causes, according to Goddard and Tredgold. The over-evaluated IQ became the decisive factor in the classification and final diagnosis of mental deficiency. This concept of intelligence and mental deficiency is untenable in the light of modern psychology and genetics.

The personality of the mental defective as that of any other human being can be understood only if the individual's life experiences with all constitutional and environmental factors involved are investigated. In other words, we must apply the methods of psychobiology to the study, treatment and prevention of mental deficiency. We must cease to conceive the mental defective as a carrier of a brain pathology disregarding entirely his environment. We must look at the syndrome of mental deficiency as an abnormal reaction pattern of the organism as a whole.

All behavior disorders, neurosis, psychosis and mental deficiency can be brought to a common denominator, that is, loss of efficiency. A normal individual shows the ability to gain the right balance between satisfaction of one's egoism and the fullfilment of social obligations, which balance assures his existence without coming in conflict with, or in dependence of the community. Behavior disorders result from a deficiency of either or both of an individual's competitive and cooperative tendencies. In a minor or major psychosis, it is the ability to cooperate at fault whereas in mental deficiency the impaired ability to compete with the other members of one's social group becomes primarily recognizable. A minor or major psychosis is characterized by a pronounced digression of emotions. Mental deficiency is conventionally defined as an arrestation of the intelligence before the individual has reached the socalled physical maturation. Psychological deficit which becomes apparent after a normal development

*At present, Agnews State Hospital, Agnew, California.

Presented before section on Physicians' Association, Department of Public Welfare, Illinois State Medical Society, 107th Annual Meeting, Chicago, May 12-14, 1947.

of intelligence and after puberty is called dementia.

The structure of personality depends on an inherited potentiality to react and on the differentiating forces of an environmental stimulation. Either one might be at fault and cause that form of social inadequacy which manifests itself as mental deficiency.

In the last one hundred years medicine was very much impressed by the revelations of biology, Virchoff's cellular pathology and later on by Mendel's famous investigations of heredity. No wonder that psychiatrists were inclined to hold heredity as etiology for many behavior disorders and especially in familiar cases where no structural or physico-chemical anomaly could be detected.

At present, it is impossible to prove directly the inheritance of mental traits. Only in such cases where abnormal mental traits are constantly associated with the same observable organic signs, is it possible to calculate a probability of an inherited etiology.

The great majority of all mental defectives, the socalled familial type included, shows no structural physico-chemical peculiarity, and most of the organic cases allow no conclusion of an inherited etiology. Of three hundred admissions at the Lincoln State School and Colony, only five cases exhibited organic stigmata similar to those reported in the history of other family members of the patients. If we consider that the percentage of the organic cases of institutionalized patients is much higher than among the mental defectives in the general population, one must infer that only about one-tenth percent of all mental defectives can be suspected of having inherited the disorder. But even in Friedrich's Disease, familial and amaurotic idiocy, Laurenc-Biedl syndrome and phenyl-peruvic oligophrenia it is very difficult to reckon the Mendelian ratio. If we realize that most of this familial and heredodegenerative types of mental defective are sterile idiots, the fear that the human race could biologically deteriorate because of a steady increase in the procreation of mentally handicapped children is without foundation. The role of eugenics in the prevention of mental deficiency must therefore be considered of minimal importance. The rarity of incidents where an inherited etiology might be taken into consideration makes it necessary to search for environmental causes in order to learn their genesis and find the right ways to treat and prevent mental deficiency.

There are two ways by which environment might produce behavior disorders, that is, by organotrope factors which strike single organs, and by psychotrope factors which affect the organism as a whole. Organtrope factors which produce structural or physico-chemical pathology are infections, mechanical traumas, and such causes which result in malnutrition, disfunction of metabolism and of endocrine glands, etc. These factors might arise in intra-and extra-uterine life and leave the more serious consequences the earlier they arise and the longer they last. The imprints of these noxious factors produce a constitutional incapacity to respond to subsequent normal stimuli of the environment.

The syndrome of mental deficiency might occur if the organism has lost the specific capacities to perceive or to conduct stimulation, or if "physical" illness inhibits the experience of those stimuli which enable the individual to cope with changing life situations. Any long lasting ailment which deprives the child of the normal environmental stimulation interferes with the normal rate of intellectual development even if the nervous system was not primarily at fault.

Among 300 new and readmissions were 118 or 39.3% "organic" cases, 50% of them were not older than 6 years, and 25% not older than 3 years. All admitted children up to 3 years were idiots of the "organic" class.

That does not mean that the same proportion is to be expected among the general population. Because there has always been relatively many more organic cases committed than the other types, this figure contrasts with the statistical data of 1943 which reported that about 20% of the total institutionalized population were of the organic type. To explain this discrepancy is to say that the commitment of organic mental defectives born in better economical layers of the general population, apparently has increased in recent years, because the traditional fear to have mentally and physically handicapped children confined in state hospitals appears to dwindle. The reasons are that emotional disturbances and embarrassment in the home of the mental defective child becomes often relieved after the sibling has been confined to an institution. Furthermore, the custodial and medical care for organically

handicapped children can be carried out in a more appropriate and economical way in a state hospital than in a private home.

Another reason to explain the difference of the percentage in the general population in 1943 and the percentage among the new admissions is the higher mortality of the organic cases. Between January 1945 and December 1945, there died 19 of the 118 organic and only one of the 182 other cases, and that was a suicide.

Psychotrope factors which elicit abnormal responses of the organism-as-a-whole are: Deprivation, frustration and overstimulation.

Cognitive functions are recognized in neuromuscular activities, in adaptation, inter-personal relations and in language. The prerequisit for these functions is a normal "physical" constitution. The development of intelligence, however, needs also an adequate environmental stimulation as a physically well developed child will exhibit a stunted intelligence if its constitutional capacity to respond has no chance to operate.

The home offers the child the first stimulations, arouses the first sensations, and conveys its first experiences. In the pre-school age it is the home which must lend to the growing child all possible opportunities to learn. Yet the child's intellectual horizon cannot expand further than the cultural limits of the home. The family gives the fundament upon which all later acquired knowledge is built and accrues. In the home the mother, or her substitute dominates the relations between the child and the field of environment. Her cultural background, emotional character, social attitude, moral code, and general education will reflect upon the child's behavior development. Provided the physical health of the child remains satisfactory, its behavior depends, during the first year of life, mostly on the emotional equilibrium of the mother. Later on, the mother's cultural inheritance and intelligence becomes an additional formative factor for its behavior. The mother, and to some extent the father, and other members of the family, and even servants, etc. determine the pattern of the child's behavior.

Conflict between parents, and economical worries might upset the emotional poise of the mother. Her irritation and anxiety, however, will pass over to the child and influence its responses, its social attitude, and morals. A disappointed, divorced, or deserted wife seeking compensation of the husband's lost love might indulge in her child — especially if it is the only one — with the result in raising a child who never will learn to consider its fellows' interests or who never will recognize any authority and might never become independent. Witnessing the parental quarrels, the child might become induced to side with either one of the parents. That might provoke further complications as rejection or hate by either parent or too much pampering by the other one. If harmony fills a family life the child will learn unequivocal rules for its orientation of life, its moral will be firmly established. If discord irritates the family peace the child will feel insecure and its concept of the world will become hazy and problematical, its behavior becomes antisocial and in some cases "allergic" to any authority. To all these abnormal family constellations, the child finally might react with anxiety, antisocial tendencies or withdrawal from contact with the environment. If this condition lasts too long, children will develop signs of a psychopathology, they might become deprived from normal environmental stimulation and consequently from the opportunities to learn, and their intelligence eventually will become deficient.

Sibling rivalry also might cause severe emotional disturbances of the growing child. Physical deficiency and the painful recognition of the inability to compete with healthy children might give rise to an inferiority complex with subsequent emotional digression: Long lasting physical ailments might induce parents to spoil a child with the result of raising a so-called problem child. Long lasting disorders due to either organotrope or psychotrope or both factors must eventually bring about an impairment of intelligence or mental deficiency. Charles Bradley writes that if an illness interrupts the development of a child even temporarily, the patient appears to have lost ground with his fellows who have gone ahead. That is true for "mental" and "physical" illness alike.

The obvious intellectual inadequacy in many neurotic and psychotic children is therefore, the result and not an underlying cause of a minor or major psychosis in childhood. This conclusion has not yet been commonly recognized and accepted for many reasons. Childhood psychiatry is a relatively new discipline and remains generally a domain of university clinics. The general practitioner who meets problem children

with signs of mental deficiency contents himself with neurological examinations and requests for intelligence tests. The too much worshipped intelligence test induces to neglect any further behavior analysis. Once a child scores a low IQ, it is usually classified as feebleminded without further attempts to apply other personality studies.

There is a large group of mental defectives with neither pronounced organic stigmata nor a history of a minor or major psychosis. These persons became intelligently handicapped primarily by a cultural deprivation and represent the Simple or Subcultural Type of Mental Deficiency. Of paramount importance, for the final development of intelligence are the first three to four years of life. During that time the child learns to associate concrete experiences with symbols, interpret and reproduce words; the child develops its linguistic habits — it learns to talk. The more opportunities are offered in the home to perceive, to see, and experience the greater will become the child's capacity to recognize, to generalize, to abstract and later on in school to comprehend. A correlation between the parents' intelligence and ethics becomes gradually noticeable — the older the child grows. The ignorance and negligence of the parents, dearth of appropriate stimulation, complicated by economical shortcomings, all these interfere with the intellectual development of the child.

Abnormal structural, emotional and cultural factors are instrumental in the production of the syndrome of mental deficiency. Disregarding the cases of "organic" idiocy, there are relatively few cases in which only one of the aforementioned etiological factors might be blamed for the pathogenesis of mental deficiency. Most cases have a mixed etiology. Many children become neurotic because of some physical handicap and very often are the emotional disturbances complicated by the cultural inferiority of the home atmosphere.

For the purpose of diagnois, however, and effective treatment, all mental defective types should be classified and treated in respect to the most pronounced deviation. Consquently, we might distinguish two main classes: one with prevailing "organic" pathology due to organotrope factors and one class without marked organic stigmata due to psychotrope factors. The second class comprises a Neuro-psychotic type with a history of a minor or major psychosis and the Simple type, with neither organic nor neuro-psychotic signs. In the aforementioned survey, there were 28.3% of the Neuro-psychotic and 32.4% of the Simple types. Among 161 morons were 11.2% Organic cases; 40.9% Neuro-psychotic cases and 47.9% Simple cases. 92.4% of the Simple morons came from poor economical conditions. Almost all of the cases which are labeled as "familial" or "undifferentiated" types, are socially handicapped victims of an unhealthy family atmosphere which is the consequence of low cultural and social economical conditions.

It is obvious that patients with outstanding neurological or other organic disturbances require a different treatment than socially handicapped morons. The care of mainly physically disabled patients must consist of hospital treatment and custodial care. Persons with little or no organ-pathology should be moved to homes or institutions where individual academic training, personality studies, rehabilitation or psychiatric treatment can be carried out.

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DISCUSSION

Dr. Louis Belinson, Dixon:

I was fortunate in that I had the opportunity to read Dr. Neuer's paper previously and could study some of the thoughts that he has presented, which type of thinking is quite prominent now in the literature. We are beginning to become somewhat more concerned about cultural and hereditary factors in the care and treatment of our defectives.

One must always consider the viewpoint when attempting to evaluate any particular thesis. I recall in my own experience that when I transferred from Lincoln up to Elgin a number of years ago. I couldn't agree with their interpretations of psychotic reactions in defectives who came to Elgin because they were psychiatrically oriented and their thoughts and ideas made the defective appear different.

At Lincoln we seem to attribute many of the behavior deviations to their defectiveness rather than considering it a problem of psychosis, and just the opposite prevailed when I came to Elgin. So when we attempt to be critical or evaluate critically, we have to be sure we are on the same ground.

Dr. Neuer presents a new classification. Every classification has defects. Yet the fact that within our institutions for the defectives we have individuals who are reading, thinking, and attempting to work out new classifications, it is in itself a most praiseworthy effort.

He handicapped us somewhat here by not completely describing his neuropsychotic type. He mav do that before he closes. I think it might help all of us.

In our own studies we didn't find so many whom we would call psychotic or neurotic prior to coming to the institution. Perhaps we didn't use the same criterion as he does. Many of the men who are now writing in this field — and recently several papers have appeared — stress heredity. I am sure Dr. Neuer doesn't feel that we should dismiss this but he tends to emphasize the cultural effect on the development of the individual's intellectual capacity.

Halperin in a recent article has shown that eighty per cent of individuals whom he studied and who were feebleminded with conditions associated with neurological disorders were idiots and imbeciles. Yet seventy per cent of the parents of this group were of normal intelligence, and it is quite well known that the lower scale defectives are more apt to be found among the more intelligent parents.

Then in a group free from physical and nervous diseases, he found thirty-one per cent of the parents defective and only eight per cent normal. Incidentally, he presents a good thought; since we are concerned with intelligence, should we consider an imbecile as being intelligent?

Perhaps, from the standpoint of studying heredity, we should consider intelligence only starting with the moron. We can take that for what it is worth. Myerson in a recent article in the November Journal of Psychiatry also stresses the fact that the heredity factor is very important, and he thinks it is probably the most important when you exclude organic factors. He finds that in school examinations of some 3500 children, seven per cent of them had one or both parents mentally defective.

As to the question of psychometric evaluation or IQ, I am sure that our present trend is away from past over-emphasis. More thought is being given to social patterns and projection techniques and I think it a wholesome trend, and it isn't giving us the concern that it did.

In evaluating data, such as Dr. Neuer presented, it may be well to present some of the figures from the Dixon State Hospital, because there has been a marked change. There has been a change in the type and character of admissions, and your statistics have to be interpreted in the light of that change.

In Dr. Neuer's group of the 300, 150 were under six years of age chronologically. One-half of them then were babies. That is a trend far different from what has been in the past. Unless that is realized, your statistics can't be interpreted properly. I checked over the year 1946 for the Dixon State Hospital and found the following data. Of the 420 admissions of feebleminded patients, not including the epileptic nor postencephalitic, we received patients ranging from eight days of age to sixty-five years of age. There were twenty-one under one year of age. There were 122 who were six years of age and under, comprising thirty per cent of those admitted during the year, whereas the nursery age group runs around four or five per cent in the institution, so you can see the admission rate of this group is entirely out of line with what we have been having.

The mean age of the 420 patients was fifteen, chronologically, whereas the mean age in the institution is twenty-seven. We can see the significant trend towards earlier admissions, and probably it accounts for the acute problem of taking care of the number of babies that have been committed. I mention this as it must affect the statistical evaluation because groups of babies surely would not fit into the subcultural group that Dr. Neuer stresses.

I feel it a privilege to have been able to read Dr. Neuer's paper previously, and to present these thoughts and comments to you.

Dr. Herman Josephy, Chicago: I enjoyed Dr. Neuer's paper very much and I agree with many of his ideas. However, I do not agree with his title and his basic conception. I think it is necessary to emphasize this point.

Neither emotional nor cultural deviations cause feeblemindedness. A child living under emotional stress may give the impression of being mentally retarded. Actually he is not. He lives and acts in

an emotional stupor, and that means something basically different from feeblemindedness. A child lacking education — the term used in its broadest meaning — is not feebleminded either. He is uneducated, and has grown up more or less as a savage. This topic has been discussed extensively in Europe 150 years ago.

If Dr. Neuer had discussed the problems from the point of view: are we doing enough for our feebleminded patients, and do we give them adequate psychiatric treatment and guidance, and a satisfactory and appropriate education — I think that all of us who have worked in institutions for the feebleminded, should feel guilty. We do not enough. Not always we get out from the inmates, especially from those on the higher levels, what one could get out. There are those who are classified as morons on account of some testing and an I.Q., and are institutionalized for years and even for lifetime. Mostly too little attention is paid to the fact that emotional and cultural deviations may impair their performance and still less is done to treat and make up for such deficits.

We know that there are quite a lot of people who according to their performance in tests are morons or even lower. However, they live outside of institutions and make a living as untrained laborers or so and do not become criminals either. I feel that institutions for the feebleminded have a number of inmates who could do the same. Making such patients fit for life by treating and repairing their emotional and cultural deviations is a worthwhile task. Probably this would be an important step against overcrowding too.

To repeat! neither emotional nor cultural deviations cause feeblemindedness. However they may put such a load on a child of average intelligence that he apparently is mentally defective. Furthermore these factors may impair essentially the performance of those who actually are mentally retarded. The assumption that such deviations cause feeblemindedness, is not justified and shifts the problem on the wrong track.

Dr. Neuer: I am very grateful for the constructive criticism of my discussants.

As to the remarks of Dr. Belinson I think there is some misunderstanding. I did not say that every patient committed as a mental defective was psychotic or neurotic at the time of admittance. I state however that there are many high grade mental defectives with a history of a psychosis and neurosis. Dementia praecoxissima is supposed to start before the age of three. It is clear that children who show a longlasting emotional digression in the early youth cannot reach a normal level of intelligence. The clinical picture of a neurotic child is characterized by vomiting spells, restlessness, night mares, tempertantrums, stuttering etc. I would not classify a child as neurotic if it should exhibit only one single abnormal trait. If a number of these symptoms are formed then we are right to take them as signs of anxiety. If that anxiety lasts too long it must reflect finally on the intellectual development. In other words emotional disturbances may produce mental deficiency.

I am aware of the fact that there have been articles recently published which emphasized the inheritance of mental traits. I think we have to go into semantics to find a satisfying answer about how heredity and mental states are interrelated. The words "heredity" and "mental" refer to different concepts. Heredity is a biological process which takes place in the cells, chromosomes. Mental deficiency, psychosis and neurosis are behavior disorders. Neurologists and biologists deal with concrete observable facts or events, whereas psychologists deal with more or less accurate descriptions of human responses. It is very hard to explain or define any mental phenomenon, because we cannot break down concepts of personality, e.g. jealousy, anxiety, to such a primitive level of conception understandable to all people in the same manner. The psychologist deals generally with quantitative deviations; the pathologist deals more with qualitative deviations. Thus it is very hard to bring both deviations to a common denominator. There is no sure way of proving inheritance of any mental traits except in cases where certain mental traits are always associated with the same organic signs.

Dr. Josephy denied that emotional factors might produce mental deficiency, without giving his definition of "mental deficiency". We have many terms referring to arrested intelligence: feeblemindedness, oligophrenia, mental deficiency etc. It is a little hard to carry on a discussion especially in psychology and psychiatry unless we can arrive at and agree on a definition.

Formerly neuropathologists thought that mental deficiency was due to a disease localized in the brain cells. Intelligence was assumed to be a function of a single organ, the brain. Whereas modern psychology considers intelligence as a behavior aspect of the organism as a whole.

The main purpose of my paper was to emphasize that the professional workers who deal with the problem of mental deficiency must treat the mental defective in a different way than has been the case in the last thirty or forty years.

Mental deficiency is not only a manifestation of brain pathology, but a deviation of human behavior. We must therefore reject every one-sided neurologyzing approach to the whole problem. Thank you.

CASE REPORTS



Additional Observations In Neostigmine Therapy

Burton J. Winston, M.D.,
Waukegan

The value of neostigmine lies in conditions which are disabling as well as painful: namely, muscular fibrositis, hemiplegia, chronic rheumatic arthritis, subacrominal bursitis, poliomyelitis, post-operative intestinal and urinary bladder atony, glaucoma, peripheral vascular disorders and myaesthenia gravis. In addition, neostigmine (Prostigimin) methylsulfate has proven itself as a test for early pregnancy.

Case 1. R.D., male, age 12, had "an operation on his lower back at the age of eight days." His mother also stated that after the age of two, he began to lose control of his bowels and urine. A communication from the hospital revealed that his condition was diagnosed as cord bladder, spina bifida, lipoma of buttocks, sphincter paralysis, and bilateral cavus deformity of feet. On July 15, 1941 he was operated on for spina bifida with no improvement.

The patient was seen June 4, 1945 because of the increasing difficulty caused by the cavus deformity of his feet. Examination at that time revealed unusually high pitched longitudinal arches. It was evident that most of the weight was being borne on the heel and ball of the foot instead of the three usual points. He was having pain in the ball of the foot and a sense of tiredness in the longitudinal arch plus cramping in the muscles of the calf. There was decreased mobility of the foot and callous of the skin over the metatarsal heads.

Neostigmine (Prostigmin) therapy was begun on June 4, 1945 at which time he received 2 cc. of neostigmine methylsulfate 1: 2,000 solution, together with atropine sulfate, gr. 1/200 subcutaneously daily for three days. The atropine was used to eliminate unpleasant parasympathetic side effects of the neostigmine. In addition, he was given neostigmine hydrogromide tablets, 15.0 mg. after each meal plus 10 min. of tincture belladonna.

After one week of treatment, the patient showed definite signs of relief. There was no complaint of tiredness in feet and legs. He did

not complain of cramps in his legs; and stated that his shoes were "becoming too short." By the end of two weeks of treatment, it became necessary for him to have larger shoes. During this period, his mother also noted that he had better control over his urine and bowels and had not once soiled his clothes or wet his bed.

One month after beginning treatment, it was necessary to obtain a second larger pair of shoes. He could walk better and was even able to run and play. Parenteral treatment was then reduced to twice weekly, but the oral dosage was maintained. When last seen on October 19, 1945, he was progressing nicely and continued to show improvement while taking only the oral medication.

Case 2, W.W., female, age 32, was a civilian employee of a veteran's hospital. On awakening one morning she was unable to turn her head. Diathermy and massage gave her no relief.

There was exquisite pain on attempting to passively turn patient's head from side to side. There was marked spasm of posterior cervical and trapezius muscles.

Within 30 minutes after the subcutaneous injection of 2cc. of neostigmine methylsulfate 1: 2000 solution together with atropine sulfate gr. 1/100, the patient began to notice less discomfort and greater range of motion of her head and neck. There appeared to be less spasm of the cervical muscles. After three injections, at daily intervals, the patient was free from pain and had normal range of motion.

Case 3. C.K., male, age 47. While doing construction work, suffered an anterior dislocation of the right shoulder. It was reduced under general anesthesia and the arm placed in a sling. After two weeks the arm was removed from the sling, and on attempting motion at the shoulder patient experienced severe pain due to muscle spasm.

He was given 2 cc. of neostigmine methylsulfate, 1:2000 solution along with atropine sulfate, gr. 1/150 subcutaneously. He observed some improvement in approximately 15 minutes. After three injections at five day intervals, he was able to return to work free from pain or limitation of motion.

Case 4. F.S., female, age 68, gave a history of having had arthritis for the past thirteen years. Her condition had been diagnosed as rheumatoid-arthritis of the knees. During the thirteen years of her illness, she had tried many forms of treatment in an attempt to alleviate the discomfort about her knees.

On physical examination patient was found to be in good general condition for her age. Her knees showed the typical changes of rheumatoid-arthritis and there was a moderate degree of muscle spasm posteriorly. During the past four years of her illness she was unable to walk a distance of two blocks because of the pain in her knees. Following the first injection of 2 cc. neostigmine methylsulfate 1: 2000 solution along with atropine sulfate of 1/200, she was able to walk with greater ease. And for the first time in four years walked a distance of two blocks. The parenteral medication was supplemented by neostigmine hydrobromide,15.0 mg. after meals and 10 minims of tincture belladonna. The injections were given every four days for six weeks, after which time she discontinued treatment. Two weeks later, the patient was unable to get out of bed because of the "intense stiffness" which she described about her knees. The injections were resumed. After the second injection she was able to get out of bed, and after the fifth (given every three days) she was again able to carry on her household duties.

After four months, treatment was reduced to weekly injections which the patient is still receiving. She has now been on neostigmine orally and parentally for two years with no signs of toxicity. Except for occasional "bad days" she is relatively free from pain.

COUNCIL MEETING MINUTES



August 29, 1948

The regular August meeting of the Council was held at the Palmer House on Sunday, August 29, with the following present: Stevenson, Camp, Hughes, O Neill, Stone, Hawkinson, Vaughn, Hedge, Saunders, Blair, Peairs, Norbury, Hulick, English, Otrich, Hamilton, Coleman, Neece, Furey, Hutton, Cross, John W. Neal, James C. Leary, Tom Jones, John A. Rogers, and Frances Zimmer.

The minutes of the June 6th meeting were approved.

The secretary read his report dealing with several items for Council consideration. (1) Michigan has adopted a "Prior to Primary Day", September 14, on which each of their Councilors hold a meeting, inviting the president, secretary, Chairman of the Legislative Committee, and the family physicians of congressmen and legislators to develop a program of personal contacts with all candidates for state or national office. This plant is offered for council consideration.

(2) The approval of the resolution introduced by E. S. Hamilton, dealing with the selection of the outstanding general practitioner for the A.M.A. annual award, was given by the A.M.A. House of Delegates. Notices have been sent to all county societies asking that they send in the name of the physician from their county whom they wish to have considered for the Illinois candidate. The Council should authorize the chairman to appoint a committee to judge these county nominations and select the representative for Illinois. Then the material can be prepared by our public relations counsel in a form suitable for presentation to the A.M.A.

(3) The Council should consider issuing an automobile emblem for members of the society. Several requests have been received asking for such a service on the part of the state society. Shall we have metal emblems which can be purchased, or stickers which can be furnished with membership cards?

A request was received from the Bureau of Accident and Health Underwriters, New York, that 100 copies of our booklet dealing with the Illinois Plan for prepaid medical and surgical care be sent to them for distribution. A letter acknowledging receipt of the material has been received, but we have not had any inquiry from any of the companies involved to date.

MOTION: (Hamilton-Vaughn) that the report of the secretary be received and made a matter of record. Motion carried.

Hedge stated that there were three items outlined in the secretary's report which required action:

(1) The consideration of instigating a "Prior to Primary Day" such as has been done in Michigan for September 14.

English: Too late for any such action this year. The matter might be considered in the future.

(2) Stevenson stated that the Executive Committee had a definite recommendation to make relative to the selection of the outstanding general practitioner in Illinois, to be the candidate for the A.M.A. award to be given in St. Louis. The executive committee recommended that the chairman appoint a committee of five, none of whom should be members of the Council, to select the candidate from Illinois, after examining all recommendations to be made by the various county societies. This

candidate from Illinois will receive a suitable certificate and medal from the State Society regardless of whether or not he is awarded the A.M.A. honor. The Committee so appointed will have power to select the candidate and the certificate and medal will be presented at the annual dinner of the state society.

MOTION: (Stevenson-Neece) that the Council concur in the recommendations of the Executive Committee. Motion carried.

(3) MOTION: (English-Otrich) that the secretary ascertain the price of 50,000 automobile stickers to be distributed to members, and report at the next meeting of the Council. Motion carried.

Stevenson reported on a letter received from Hopkins in Hawaii, mentioning several important items for Council consideration. The dinner for the members of the A.M.A. House of Delegates held at the Saddle and Sirloin Club during the A.M.A. meeting was a definite success and an excellent public relations gesture.

Dr. Hopkins also wanted to report to the Council that a new contract had been signed with the Veterans' Administration in the program to supply medical care at home for veterans with service-connected disabilities.

Dr. Warren Furey reported as Vice-Chairman of the Committee on Voluntary Prepayment Plans for Medical and Surgical Care. The committee met on August 3, and at this meeting, approved an overall policy issued by the Metropolitan Casualty Company of New York, pending action on the part of the Department of Insurance of the State of Illinois, and a final check by the general council.

The Bankers Life and Casualty Company of Chicago was taken off the approved list by committee action.

A special organization embodying representatives of those states where an indemnity plan is in operation, of where such a plan is contemplated, is being formed. The group of some eight state representatives met during the A.M.A meeting, then met again later that week with representatives of the A.M.A. Council on Medical Service. This summer a meeting was held in Madison, Wisconsin, which was attended by representatives of Illinois and Wisconsin, plus Howard Brower of the A.M.A. Council. This group suggested a name for the new national organization, "The Conference of Medical Society Prepayment Plans", and the state society committee has requested approval from the Council to participate in this national organization, and also to become a part of the setup.

MOTION: (Hughes-Hawkinson) that the Council approve the report of the committee and approve the participation in the "Conference of Medical Society Prepayment Plans". Motion carried.

Dr. John A. Rogers, Director of the Illinois Division of the American Cancer Society, and Tom Jones, medical artist, appeared before the Council bringing a working model of the contemplated exhibit of the American Cancer Society to be installed in the Museum of Natural Science in Jackson Park. The total cost of the finished exhibit will be some $50,000 and before further work is done, approval of the Council is desired.

The exhibit will be the finest of its kind in the world, and will depict the state of Illinois, the city of Chicago, and by graphic lights, will show: resources for the control of cancer (physicians, information centers, detection centers, cancer clinics, etc.) The exhibit must give specific information to be of value, and the Illinois Division desires approval of their contemplated plan to give the actual names of cancer clinics and the means of making use of these facilities. Some $800,000 has been made available to the Illinois Division for this year's work.

MOTION: (Hamilton-English) that the Council approve the plan as outlined by Doctor Rogers and Tom Jones. Motion carried.

Stevenson reported as President-elect stating that the Illinois Society for the Prevention of Blindness has established a program in Illinois which will include the screening of all school children for eye defects. This screening test is to be established on a standard basis of testing, and the Society wants two ophthalmologists and two optometrists to perfect the program. The Council should approve the services of these two ophthalmologists and also approve the contemplated program.

MOTION: (Stevenson-Neece) that the Council approve this proposed program pending an investigation by the president-elect, and that the Council sanction the appointment of two ophthalmologists to serve on this committee. Motion carried.

Stevenson discussed the use of county health units to give free care in prenatal cases, and in many other fields of medicine — whether the patient is able to pay for such care or not. He felt that the Council should go on record stating that adequate prenatal care in the office of a private physician is not denied to anyone, and that the county societies should oppose any such action on the part of a health center. The Department of Public Health and the local units will not participate in any such program unless it is approved by the county society, and the county societies should be informed that the Council of the state society has expressed adverse opinions relative to this type of work. Such an expression on the part of the Council gives the county society something to "back them up" when approached along these lines by any lay group.

MOTION: (Stevenson-Hawkinson) that the Council concur in this opinion, and that a letter be sent to each county society secretary giving this information. Motion carried.

Hedge stated that if the Council felt that the Councilor Districts should be more compact, and such change would necessitate a change in the Constitution and By-Laws, and should be referred to the Constitution and By-Laws Committee.

The Journal Committee met on August 27, and discussed several changes, new headings, etc., as

started in the July issue of the Journal. Some ads are being dropped and others added. The pages of pictures appearing in the August issue illustrate graphically the new stock.

The request that the state study the need for a bill to control alcoholism resulted in the appointment of a committee to investigate the need for such legislation. On the committee are A. J. Carlson, Ivy, Norbury, Cross, Neece, Stevenson. Other states where such legislation is in force are being contacted, and an investigation is being conducted.

Hedge called the attention of the Council to the article on antivivisection which appeared in the July 24th Saturday Evening Post.

Hutton reported as Chairman of the Committee on Medical Service and Public Relations. A meeting was held Sunday morning at the C.A.A., and various questions were considered. Dr. Frederick Slobe had requested society approval of a contemplated industrial radio program which should go on the air September of this year. The Chicago Medical Society Council will also be contacted for an expression of opinion. The radio program of the A.M.A. was also discussed, and the part Illinois is to play in this picture was considered. The office of the secretary should get in touch with W. W. Bauer about this work so that correct cooperation from this state can be given.

Hutton reported as Chairman of the Committee on Medical History, a meeting was held on June 1, then a sub committee got together on June 20 to discuss the proposed contribution from the pediatricians. Black, Hoyne, Hess, Richardson and Crawford of Rockford were present, and the field was divided. The committee feels it is on firmer ground, and that more definite progress is being made.

Otrich reported that he had been attending a meeting in Randolph County and when there, he had gone to view the grave of Dr. George Fisher, pioneer physician and first speaker of the House of Representatives of the State of Illinois. The grave lies nine miles from the Ruma-Murdock chat road, near St. Leo's Church on the highway right-of-way, and has been marked with a large bronze historical placque. However, changes in the road bed, erosion, etc., are destroying the cemetery lot where this physician is buried. Cement curbings should be poured, and something should be done as soon as possible in order to preserve what is left of this family plot.

MOTION: (Otrich-Hamilton) that the secretary write to the Governor and call the situation to his attention so that he can refer the matter to the proper department for action. Motion carried.

Hamilton discussed the proposed draft bill which would affect members of the medical profession. There is a definite need for 6,000 doctors by January 1, 1949, and if this number is not recruited voluntarily, the draft bill, already prepared, will be presented to the House and Senate. Of this group, Illinois should furnish between 500 and 800. Men who received their education at the expense of the government, members of the medical profession who entered this country as a "Displaced Person" have a financial and moral obligation to serve. Those of this group who have not seen military service should be requested to enlist for a term of one, two or three years.

Editorials should appear in the Illinois Medical Journal, a list of these men should be secured and distributed to the Councilors so that personal contact can be made. Universities with young men in research should be encouraged to release men eligible for military duty. The public relations program should be intensive along this line, and newspaper releases should be forthcoming. Public opinion will be the only actual means of encouraging enlistment of these men.

Leary suggested that the matter be handled on the basis of a "resolution passed by the Council", and that this might make a better appeal as a news release. The material was prepared and submitted for approval.

MOTION: (Otrich-English) that the resolution be approved. Motion carried.

Leary presented his portion of the report for the Committee on Medical Service and Public Relations, stating that the work for the committee on Rural Health had been very successful; the publicity sent out for the annual meeting of the society was well received, and good cooperation was received from the various speakers. Assistance has been given to the ophthalmologists, and a news release was prepared for distribution in the court room.

John W. Neal reported as executive secretary of the Committee on Medical Service and Public Relations stating that the activities of the committee would increase when the political campaigns got under way. Endorsement letters will be sent out in the near future.

Since there were no objections, the chairman ruled that the report of the committee be accepted and placed on file.

Blair reported as chairman of the Educational Committee stating that a meeting was held on June 21, and since that time, routine work has been progressing nicely. The industrial group headed by Slobe has requested that their broadcasts clear through the Educational Committee. Someone in authority has to sign for the release of the material; Dr. Hedge and Dr. Hopkins have taken care of this recently. This problem should be considered by the Council, and Miss Fox authorized to sign as secretary of the committee.

Miss Fox has been asked to join the Business and Professional Women's club and has been able to arrange programs on health since her membership was accepted.

Health Talk continues to be popular, and the card file of those who receive it is in constant revision so that no dead material goes out. There are many individual requests for certain issues of "Health Talk", and these requests have been filled.

The Society Exhibit was on display at the State Fair at Springfield with Miss Fox in attendance the first three days; after that time, the Woman's Auxiliary in Sangamon County took care of the booth. We would like to suggest that the secretary's office send a letter of appreciation for this work. Some 5,000 "Prepayment Pamphlets" and some 4,000 "Doctors and Horses" were distributed.

At this time, Miss Fox is assisting the Chicago Medical Society in their booth at the Cook County Fair, and some of her material, presented at the county level, is on display there.

The question of the sponsored radio program has been discussed several times, and still presents a problem. The industrial health program outlined by Dr. Slobe has been worked out under the supervision of a radio man, and should be well received.

The request of the industrial group that we listen to the first "take" on their releases for radio may cause some difficulty. The only two Chicago men on our committee are Dr. Hick and Dr. Furey. This request might be too heavy a load for these men to assume, and if such is the case, we would like to have Council permission to have the Chairman appoint two liaison men from Chicago to take over this responsibility and to listen to these programs if it is needed.

MOTION: (Hamilton-Coleman) that this request be granted. Motion carried.

Rhode Island, New Hampshire and New Jersey all have radio programs; Rhode Island offers their program to other states. In the past such work has been done without sponsors, but perhaps the coming programs will have commercial sponsors. A medical director for television has been brought from New York to Chicago for work to begin shortly, so the importance of this is obvious.

WLS plans a medical program, and has requested aid from the Illinois State Medical Society in working over a health chart presenting various fields of medicine that might be presented on the air.

The Chairman ruled, since there were no objections, that the report be accepted and placed on file.

Coleman reported that the I. P. A. C. work was progressing in a routine fashion and that a meeting had been held Saturday evening.

He also reported that following the contribution from the American Cancer Society to the National Health Council, sponsored by Ewing, he wrote to the national headquarters. They explained their action on the matter was based upon the fact that the A.M.A. was participating in the meeting and that Fishbein was one of the main speakers. The reply given was that naturally the A.M.A. must participate in order to protect members of the medical profession, but that the reaction in Illinois was definitely unfavorable to contributions being given by such organizations as the American Cancer Society, Red Cross, and the National Foundation.

Camp reported that a committee report had been received from Gerard N. Krost on the Committee on Fetus and Newborn, which he would have mimeographed and sent to all members of the Council with the minutes of this meeting.

Cross reported as Director of the Department of Public Health, and stated that he had developed forms for the application for state and federal funds under the Hill-Burton Bill for the construction of hospitals in Illinois. These can be prepared for publication in the Journal if such is the desire of the Council.

The Board of Public Welfare Commissioners has developed an Illinois planning Committee to meet to make plans for a conference to be held in Washington in March, in anticipation of the 1950 White House Conference on Children. The Illinois State Medical Society should have a representative at the 1950 meeting, and should also have a representative on the Planning Commission.

The State Department of Public Health had an excellent exhibit at the State Fair, located next to that of the I.S.M.S.

The question of the advisability of placing benzedrine inhalers under state control for sale by prescription only should be considered by the Council. Perhaps this action should be taken by the 66th General Assembly so that the distribution of benzedrine can be controlled.

MOTION: (English-Hamilton) that Dr. Roland R. Cross be appointed as the representative of the Illinois State Medical Society at the 1950 White House Conference. Motion carried.

MOTION: (Otrich-Norbury) that the problem presented by the distribution of benzedrine be referred to the Committee on Medical Service and Public Relations. Motion carried.

O'Neill as Councilor, reported on the hospital situation in Princeton, following receipt of a complaint which dealt primarily with the question of anesthesia in the hospital. After discussing the problem with most of the men working in the hospital, it was O'Neill's opinion that conditions compared very favorably with those existing in any small hospital with similar equipment. One physician has been specifically trained in anesthesiology, and returns for postgraduate work periodically. Various types of anesthesia are in use, and the nurses giving ether anesthesia have been trained for the work. There has been one maternal death in the past five years. The situation seems perfectly in order, and not one to cause any alarm.

Otrich reported as Chairman of the Committee on Nutrition. A meeting of the Farm Foundation was held on July 12 at the Union League Club of Chicago with representatives present from many various fields. Funds are available to this group "for the advancement of agriculture", and they plan to set up a program for future work. Nutrition and its relation to the soil is their main aim, and the education of the medical profession, the farm group, etc., is contemplated. The next meeting of the Illinois State Medical Society should have a speaker

before the general assembly on this subject, and the medical profession should be better informed along all these lines.

MOTION: (Hamilton-Hawkinson) that W. C. Bornemeier be appointed as Vice-Chairman of the Committee on Arrangements for the 1949 annual meeting of the I.S.M.S. Motion carried.

MOTION: (Hamilton-Stevenson) that the Chairman of the Council appoint a representative of the Illinois State Medical Society to the Illinois Planning Commission as requested by Dr. Cross. (Next meeting to be held September 8.) Motion carried.

The International Travel Service has requested that the Illinois State Medical Society sponsor a special train to the A.M.A. meeting in Atlantic City in June, 1949.

MOTION: (Hamilton-Hawkinson) that the matter be referred to the Chicago Medical Society. Motion carried.

At the request of Benjamin Wham, Chairman of the Public Health Committee, the Chairman of the Council made the following appointments:

Dr. Arkell M. Vaughn, to attend the meeting at the Stevens Hotel, Chicago, 1:00 p.m., September 17.

Dr. Charles O. Lane, to attend the meeting in Mt. Vernon, Hotel Emmerson, 10:00 a.m., September 24.

MOTION: (Hamilton-Saunders) that the Chairman of the Council name a physician to act as a member of the state committee being formed by the Illinois Epilepsy League, Inc. Motion carried.

MOTION: (Hamilton-Stone) that the Council approve the action of the secretary in purchasing additional files for the Carl E. Black-Illinois State Medical Society Collection at the State Historical Library, and that future actions of this nature be approved. Motion carried.

MOTION: (Stevenson-Hughes) that the following members be elected to Emeritus Membership: H. N. Rafferty, Robinson, Crawford Co.; G. S. Botts, R. F. D., Canton, Fulton Co., C. H. Hamilton, Canton, Fulton Co.; E. G. Fuller, Gardner, Will-Grundy Co.; Horace Dunn, Spring Valley, Bureau Co.; Egbert Fell, Rockford, Winnebago Co.; Rollin Rice, Savanna, Carroll Co.; S. Frank Russell, Macomb, McDonough Co.; John W. Montgomery, Birds, Lawrence Co. Motion carried.

MOTION: (Stevenson-Vaughn) That the following members be elected to Past Service Membership: C. J. Poole, Mt. Vernon, Jefferson-Hamilton; Robert R. Smith, Mt.Vernon, Jefferson-Hamilton; George Knappenberger, Macomb, McDonough; Ernest F. Lidge, Mundelein, C.M.S.; Arthur M. Butzow, 4205 N. Mozart St., C.M.S.; O. E. Fink, Danville, Vermilion; T. J. Carmody, Danville, Vermilion; M. D. Henderson, Franklin, Morgan; Benson M. Jewell, Danville, Vermilion; W. C. Mershimer, Shawneetown, Gallatin. Motion carried.

MOTION: (Stevenson-Otrich) that the bills as audited by the finance committee be approved. Motion carried.

The Council adjourned at 12:45.

HAROLD M. CAMP, M.D.
Secretary

THE GENERAL PRACTITIONER

Before any physician can be a competent specialist he should be a good doctor, and should be well acquainted with all of the diseases of the human body. It, therefore, might be well to urge that the specialty boards require that each applicant have at least three years' experience in general practice before specializing, and that hospitals reserve a major portion of their resident training positions for men with such experience. The specialty training program then could be lessened, because out of his own experiences the physician would have acquired unusual training that especially fitted him for any type of medical practice.

The general practitioner is a vital part of our system of medical care. He should not be denied the proper use of available hospital facilities. There are certain intricate procedures that must be limited to specialists in that field, and the competent general practitioner will recognize his limitations. Our present system of medical care is very complicated, and no one can cover the whole field. The specialist and the general practitioner are equally necessary.—Cleon A. Nafe, M. D., in J. Indiana St. Med Assn.

NEWS OF THE STATE



ADAMS

Physician Honored.—Dr. W. E Davidson, who has practiced in Liberty for forty-seven years, was publicly euglogized Labor Day when the community held a basket dinner in his honor. Dr. Davidson graduated at Keokuk College of Physicians and Surgeons at Keokuk, Iowa, in 1901.

BUREAU

Blessing of Hospital Launches New Drive.—The new million dollar wing of St. Margaret's Hospital in Spring Valley was blessed with appropriate ceremonies August 28. The occasion marked the formal opening of a new campaign to raise $375,000 to complete the building and to obtain additional furnishings. Dr. George E. Kirby, Spring Valley, has been chosen chairman of the new campaign. In a statement to the press Dr. Kirby said "Our families, the city of Spring Valley, the rural territory immediately adjoining, outlying villages and towns and even some of the larger cities in the general area will benefit from this great modern institution, equipped to deliver just about every possible kind of health service. The Sisters of St. Mary of the Presentation who have operated St. Margaret's Hospital since its founding in 1903 should be commended for so bravely undertaking this expansion program."

CHAMPAIGN

Personal.—Additions to the staff of Carle Hospital include Doctors Lowell L. Henderson, Carleton Allen Keck and Frederick K. Sargent. Dr. Henderson, has been named head of the department of allergy, Dr. Keck, a member of the eye, ear, nose and throat staff, and Dr. Sargent has been named to the pediatric staff.

COOK

Dr. Huggins Awarded Fenwick Prize.— Dr. Charles Huggins, professor of urology at the University of Chicago School of Medicine, has been awarded the Fenwick Prize, a gold medal, by the Societe Internationale D'Urologie for work on the endocrine control of cancer of the prostate.

Research in Biochemistry.—The University of Illinois College of Medicine has received $7,000 from Mead Johnson and Company, Evansville, Ind., to support a two year fellowship in research in biochemistry in the department of pediatrics, under the supervision of Dr. Henry G. Poncher, head of the department.

New Head of Radiobiology Institute.—Thorfin R. Hogness, Ph.D., has been appointed director of the institute of Radiobiology and Biophysics at the University of Chicago. He succeeds Raymond E. Zirkle, Ph.D., who has become professor of radiobiology.

Dr. Westlake Honored.—Harold Westlake, Ph.D., Winnetka, associate professor of speech re-education, Northwestern University, has been awarded a scholarship for specialized training in cerebral palsy by the National Society for Crippled Children and Adults, Inc., Chicago. Dr. Westlake is one of the first in the new national program established to meet the challenge of a crippling condition that disables some half-million Americans, the society announced.

Public Health Meeting.—Featuring two one-day sessions of discussions by outstanding authorities in the fields of public health and education, the sixth annual conference of the Illinois Statewide Public Health Committee was held at the Stevens Hotel in Chicago, September 17, and at Hotel Emmerson in

Mt. Vernon, September 24. Benjamin Wham, Chicago, and Mrs. Walter Stevenson, Quincy, are co-chairmen of the committee.

The purpose of these meetings is to provide information regarding the services of county health departments. Definite health education and campaign procedures were outlined for Illinois counties expecting to vote on the establishment of such a department in the November election.

Highlighting the program in Chicago was an address by Hugh Masters, educational director of the W. K. Kellogg Foundation, Battle Creek, Michigan. Mr. Masters spoke on the subject "Local Public Health Service and a Voluntary Health Agency." Dr. Arkell Vaughn, Chicago, Councilor of the Illinois State Medical Society, represented the society at the meeting.

Among the outstanding speakers at the Mt. Vernon meeting was Dr. W. W. Bauer, director of the bureau of health education of the American Medical Association, Chicago. Dr. Bauer is a national authority in the field of health education.

It was announced that the entire program of both the northern and southern sections of the conference is in line with the objective of the Statewide Public Health Committee "to promote adequate public health services for every area of the State." This committee has in its membership more than 5,000 "health-minded" citizens of Illinois.

Grants for Research.—Seven research grants totaling $32,154 have been awarded the University of Illinois college of medicine in recent weeks, Dr. A. C. Ivy, vice-president, has reported.

The Office of the Surgical General, Department of the Army, has awarded a $10,000 grant for the "Pharmacodynamic Study of Renal Blood Flow." This investigation will be conducted by the department of pharmacology, under the supervision of Dr. Jules H. Last.

The U. S. Public Health Service has awarded the college of medicine separate grants of $6,000 and $5,500 for visual education depicting clinical manifestations of uterine carcinoma to be undertaken under the supervision of Dr. Frederick H. Falls in the department of obstetrics and gynecology, and for a study of the physiological effects of the influenza virus on the mammalian host to be conducted under the supervision of Dr. J. E. Kempf in the department of bacteriology.

Parke, Davis and Company has made a $5,000 grant for the development and evaluation of antihistamine and adrenergic blocking agents. The study will be conducted under the supervision of Dr. E. R. Loew in the department of pharmacology.

Ayerst, McKenna and Harrison, Ltd., has awarded a $3,960 grant for a research project on "Urogastrone" to be conducted by the department of clinical science under the supervision of Dr. M. I. Grossman.

Other research grants have been received from the American Pharmaceutical Association and the Upjohn Company.

Dr. Knisely Awarded Alvarenga Prize.—In recognition of his studies on "Sludged Blood" the College of Physicians of Philadelphia on July 14 awarded the Alvarenga Prize for 1948 to Melvin H. Knisely, Ph.D., former associate professor of anatomy, University of Chicago School of Medicine. The Alvarenga Prize was established by the will of Pedro Francisco da Costa Alvarenga of Lisbon, Portugal, an associate fellow of the College of Physicians of Philadelphia. The college invites the recipient to deliver the Alvarenga Lecture. Dr. Knisely became head of the department of anatomy at the Medical College of the State of South Carolina, Charleston, July 1.

Dr. Kleinschmidt Named to New Post.—Dr. Earl Kleinschmidt, Oak Park, became Oak Park's health commissioner on September 1. Dr. Kleinschmidt succeeds Dr. Gilbert P. Pond, resigned, who held the position for some four years.

New Committee to Project Health Promotions.—Plans for a determined drive to put into effect the recommendations of the Chicago-Cook County Health Survey, completed last year, will be the duty of a committee now being formed under sponsorship of the Health Division of the Council of Social Agencies of Chicago.

Chairman of the committee, already selected, is Samuel A. Goldsmith, director of the Jewish Charities, now in Europe surveying relief operations. Other members will be announced later, according to Miss Mary E. Murphy, director of the Elizabeth McCormick Memorial Fund and chairman of the Health Division.

The division is now making a study to determine how many recommendations of the Survey have already been adopted by the numerous governments and other agencies of the county. When that is complete, the most important remaining elements, such as the expansion and financing of health departments, will be outlined for an intensive campaign throughout the county.

The Survey, first step in the postwar rehabilitation effort of Chicago's health agencies, was made by the United States Public Health Service, at the request of Edward J. Kelly, then mayor, and Clayton F. Smith, then president of the County Board. They acted at the suggestion of a committee representing the Council of Social Agencies, the Chicago Medical Society and the Institute of Medicine of Chicago.

The United States Public Health Service organized a team of some two-score experts in various phases of health activity, which spent six months in the work. Their reports, 41 in all, containing more than 450,000 words, evaluated the good and bad of the health facilities of the community and made detailed and practical recommendations for improving them, where needed.

The Survey as a complete "audit" of the health protection of a great metropolitan area, is considered a milestone in the history of public health.

No other community has ever undertaken so tremendous a task. Chicago's feat is already serving as a model or stimulus to other cities.

The text, which will be nearly 1,200 pages long, plus numerous charts, maps, tables and pictures, will shortly be published by the Columbia University Press. Meanwhile, a condensed, non-technical, low-cost version in pocket-size about 100 pages long, called "Blueprint for a Healthy Community," has been printed for general use, and is available at the United States Public Health Service office, 610 South Canal Street.

Major emphasis in the coming campaign is expected to be placed on the expansion of the Chicago Health Department and the Cook County Department of Public Health.

Faculty Appointments at Illinois.—Appointment of eight physicians to positions of professorial rank on the faculty of the University of Illinois College of Medicine has been announced by Dean John B. Youmans.

Dr. S. Howard Armstrong, Jr., has been appointed professor of medicine. A graduate of Princeton University and Harvard medical school, Dr. Armstrong now serves as chairman of the department of medicine at Presbyterian hospital.

Drs. William S. Hoffman and Robert E. Johnson have been named professorial lecturers in physiology. Dr. Hoffman, who has achieved an excellent reputation in certain fields of biochemistry, medicine, and physiology, serves as director of biochemistry at Cook County Hospital Laboratories and Hektoen Institute for Medical Research.

Dr. Johnson holds the position of director of research at the Medical Nutrition Laboratory. His research activities have involved studies in the fields of nutrition, exercise physiology, and industrial physiology.

Drs. Samuel A. Leader and Harry Slobodin have been appointed to the faculty with the rank of clinical assistant professor of radiology. Dr. Leader, a graduate of the University of Chicago and Rush Medical College, is chief of diagnostic x-ray at Vaughn unit, Hines. Dr. Slobodin, a graduate of Columbia University and New York University medical school, has served as chief of the department of radiology at the Veterans hospital since 1942.

Dr. Rudolph Novick has been appointed clinical assistant professor of psychiatry. Dr. Novick has achieved recognition as director of the Illinois Society for Mental Hygiene.

Dr. Joseph E. Bourque who has gained research experience in the fields of gastric motility, gastric secretion, shock, and nutrition, has been appointed an assistant professor of physiology. He previously taught at the University of New Hampshire, Cornell University, Loyola University of New Orleans, La., and Wayne University.

Dr. James A. Campbell has received an appointment as assistant professor of medicine. A graduate of Knox college and Harvard medical school, he now serves as assistant attending physician at Presbyterian hospital.

Progress in Building Plans for Medical Center.—More than $50,000,000 for building construction to take place within the next five years is now in the blueprint stages for the Medical Center District on Chicago's near West Side.

Planned construction will bring the Medical Center District one step nearer to the ultimate goal of $300,000,000 valuation which has been predicted for it by Dr. Walter H. Theobald, president of the Medical Center Commission.

The present value of land, buildings, equipment, and facilities in the Medical Center District is now estimated at nearly $100,000,000. It is the largest in the world in terms of money invested in educational and hospital facilities. The 300-acre district is bounded by Congress street, Oakley Blvd., Roosevelt road, and Ashland Blvd.

Building projects on the drawing board include the $15,000,000 Veterans Administration hospital. Ground will be broken sometime in 1949 for the 1,000-bed hospital which will be located in an area bounded by Taylor street, Damen avenue, Polk street, and Ogden avenue. Selection of that site near three medical schools and affiliated institutions will enable the hospital to secure an outstanding staff and to extend to patients the best in medical care.

Another large project will involve improvements and expansion of physical facilities of the Cook County Hospital group. Cook County voters passed a $7,000,000 bond issue last spring for a program which will include the construction of a new residence for interns and extensive modernization of the present buildings.

Construction of the state's new $6,000,000 tuberculosis hospital also will be started next year. The 500-bed institution will be located in the 10-acre block bounded by Taylor street, Damen avenue, Roosevelt road, and Wolcott street.

The most immediate construction project which will be undertaken in the District will be the breaking of ground this fall for the Institution of Tuberculosis Research on Polk street, near Wood. The $361,000 Institution will produce and distribute the vaccine, BCG, which has proved to be highly effective in preventing tuberculosis in children as well as adults. It will be operated jointly by representatives of the University of Illinois, the Research Foundation, and the Municipal Tuberculosis Sanitarium.

Loyola University will spend $5,750,000 for erection of a building to house its School of Dentistry and the Stritch School of Medicine. The school building will face Harrison street, from Damen avenue to Hoyne avenue. The University is now conducting a $12,000,000 fund campaign, one-fourth of which is being sought this year.

Other institutions in the Medical Center District which are planning construction within the next

five years are Presbyterian hospital, the Chicago Medical Society, the Cook County Graduate School of Medicine, and the West Side Professional Schools YMCA.

In addition, the University of Illinois is preparing recommendations for its building program to submit to the state legislature. The University building committee is now considering an $18,700,000 construction program which would include an addition to the 428-bed research and educational hospitals, a classroom and laboratory unit addition to the Colleges of Medicine, Dentistry, and Pharmacy, and a nurses' residence and school. Private financing is being sought for a student residence.

Several plans also are under consideration by insurance firms, large-scale builders, and others for the construction of modern, 10-story apartment buildings to be located in the District.

Society News.—Dr. Meyer A. Perlstein held clinics at the annual convention of the California Society for Crippled Children in San Francisco, September 23-26. On October 19, he addressed the Marquette-Alger Medical Society in Marquette, Mich., on "Differential Diagnosis of Convulsions in Children."—Dr. Philip Thorek presented a paper on "Vagotomy and the Ulcer Problem" with colored motion picture demonstration before the Ninth Harlow Brooks Memorial Navajo Clinical Conference, Ganado, Ariz., August 30.—Dr. Max Thorek addressed the Wyoming Surgical Section of the United States Chapter, International College of Surgeons, at Laramie, Wyoming, August 31, on "Hirschsprung's Disease."

Personal.—Dr. John T. Reynolds, clinical assistant professor of surgery, University of Illinois College of Medicine, is spending three months abroad in graduate study.—Dr. Stewart H. Walpole opened offices in the same suite with Dr. C. H. Kramer at 125 West Chicago Avenue, Palatine, recently. He will confine his practice to general surgery.

DE KALB

DeKalb County Opens Child Welfare Unit.—The first child welfare unit in northern Illinois was recently established in DeKalb county and now is a going concern. Funds had been appropriated for the project by the county board of supervisors at their June meeting. Temporary quarters were established in the DeKalb township relief office of Thomas Olsen. In charge is Miss Mary Andrews, Sterling, who was provided by the division of child welfare, Illinois Department of Public Welfare. Miss Andrews has her master's degree in social work from Washington University, St. Louis, and previously was in charge of the unit in Jackson county.

Such a joint state-county project has been operating in southern Illinois for several years. The purpose of the unit is to provide services for children and referrals come chiefly from the county court, township supervisors, schools, public health nurses and the county departments of public assistance. Casework is provided for families undergoing difficultities with their children, for prevention of family break-ups and for effecting proper adjustments.

DOUGLAS

Personal.—Dr. Grant A. Jones, formerly of La Salle, has engaged in the practice of medicine in Arthur. Dr. Jones graduated at the University of Illinois College of Medicine in 1944 and served his internship at Grant Hospital, Chicago, where he had recently been a resident physician in pathology.

EDGAR

Dr. Jennings Retired.—Dr. J. Frank Jennings, Chrisman, recently retired from active practice. In his public announcement, Dr. Jennings said he wished to thank all the people for their many acts of kindness in his fifty-four years of service. He first started the practice of medicine in Scottland, Ill., moving to Chrisman in 1922.

FRANKLIN

New Member of Advisory Board.—Dr. R. C. Steck, Christopher, has been appointed a member of the advisory board of the Institute for Juvenile Research. The advisory board, with headquarters in Chicago, is made up of persons known to be interested in promoting the rehabilitation of children who are delinquent, mentally ill or defective or socially maladjusted.

Dr. Steck was formerly president of the Franklin County Medical Society, is vice-chairman of the Franklin County Cancer Society and the Franklin County division of the National Foundation for Infantile Paralysis and is a member of the Illinois Welfare association and the Illinois Rehabilitation association. He is a staff member of the Herrin Hospital.

KANE

Personal.—Dr. Vernon L. Evans has resigned as medical director of Mercyville Sanitarium to devote all of his time to the private practice of medicine in Aurora.

Society News.—Dr. Arkell M. Vaughn, Chicago, addressed the Aurora Medical Society, September 2, at the Sky Club, Leland Hotel Aurora, on "Vagotomy in the Treatment of Gastro-Intestinal Ulceration."

KANKAKEE

Physician Retires.—Dr. A. S. Eshbaugh, who was practiced in Kankakee for more than fifty years, retired from active service, September 1. Dr. Eshbaugh graduated at Hahnemann Medical College, Chicago, in 1886 and began practice in Lexington. He then moved to Chicago but went to Kankakee in 1897. The physician is eighty-nine years old.

LA SALLE

Memorial Planned for Physician.—A public meeting was held in Ottawa, August 25, to discuss

plans for a suitable memorial to perpetuate the memory of Dr. C. J. Stricker, a Marseilles physician who died recently. Among the suggestions were the establishment of a hospital for Marseilles; a chimes tower for Riverview cemetery; or a bronze honor roll bearing the names of all Marseilles men who served in World War II.

Personal.—Dr. Joseph L. Jernegan recently became associated with his father-in-law, Dr. G. K. Wilson, Streator.

MACON

Blue Cross Dinner.—On September 3, the Macon County Medical Society was the guest of the Illinois Hospital Service Corporation at a dinner in the St. Nicholas Hotel, Decatur. Dr. Frank P. Hammond, medical director of the Illinois Hospital Service Corporation discussed "Professional Interpretation of the Blue Cross Membership Certificate." Other speakers included Mr. C. N. Andrews, assistant director in charge of Hospital Relationships and Mr. E. P. Lichty, executive director.

Personal.—Dr. Robert R. Harriage moved to Aurora recently to engage in the practice of obstetrics and gynecology. He is transferring his membership to the Kane County Medical Society.

MACOUPIN

Society News.—The Macoupin and Montgomery County Medical Societies met jointly in Carlinville recently to hear Dr. O. P. J. Falk, associate professor of internal medicine, St. Louis University School of Medicine. Dr. Falk's subject was "Therapeutic Problems in Medical Practice."

MADISON

Hospital News.—A cornerstone for the new Wood River Township Hospital was recently laid with special ceremonies. Dr. Maurice Woll was chairman of the committee. Dr. L. D. Archer, president of the Wood River Township Medical Society, was among the speakers.

Society News.—"Behavior in Childhood" was the subject of a film shown before the Madison County Medical Society at its meeting at the Madison County Sanatorium, Edwardsville, September 2. The film was prepared by the American Academy of Pediatrics.

ST. CLAIR

Personal.—Dr. William F. Rose has resigned as head of the surgical service at Jefferson Barracks Veterans Hospital to go into private practice of medicine in Dupo. He will confine his practice to general surgery.

RANDOLPH

Randolph Health Unit Approved.—At a special meeting of the Randolph County Medical Society recently, unanimous approval of the proposed bi-county public health department was given and members of the society voted to cooperate in setting up the health organization. Dr. W. W. Fullerton, Steeleville, secretary of the society, in a statement to the press, said that the Monroe County Medical Society had previously disapproved the formation of a Monroe-Randolph Medical Health Department but it was understood that this agreement was temporary. Dr. Fullerton believes that since the Randolph County physicians have given their approval, similar action will be taken by the Monroe County group.

SANGAMON

Society News.—Dr. Louis R. Limarzi, Chicago, will address the Sangamon County Medical Society, November 4, on "Diagnosis and Treatment of Hematological Disorders." Dr. Charles B. Puestow, director of surgery, Hines Hospital, addressed the society September 2 on "Post-Operative Biliary Physiology."

Fifty Year Member.—Dr. Albert L. Stuttle, Williamsville, was presented with his pin and certificate of membership of the Fifty Year Club at the June 1948 meeting of the Sangamon County Medical Society. Following an introductory talk by Dr. James Day, member of the Fifty Year Club, and the presentation of the tokens of membership by Dr. Kenneth H. Schnepp, Doctor Stuttle addressed the society on "The Progress of Medical Practice in the Past Fifty Years."

GENERAL

Telephone Used in Graduate Work.—Dentists and physicians in Illinois and surrounding states were afforded an unusual opportunity this fall to attend an evening postgraduate course in Cancer Control and Oral Diagnosis through the transmission of the lectures by telephone to five Illinois cities.

The unique presentation originated at the University of Illinois college of dentistry, located in the Medical Center District on Chicago's West Side. The lectures were transmitted via telephone to groups of dentists and physicians who will convene in Belleville, Peoria, Rockford, Springfield, and Urbana. Urbana.

The course is being offered via telephone to give a greater number an opportunity to enroll. Facilities at the University of Illinois college of dentistry permit only 200 to attend personally the course which consists of six lectures.

The Illinois division of the American Cancer Society, the Illinois State Dental Society, and the Illinois State Medical Society cooperated with the University of Illinois in offering the first course which started October 6. The tuition charge for the course has been waived, through the courtesy of the Illinois division of the American Cancer Society.

Regional Meeting on Heart Disease.—The Illinois Heart Association, in co-operation with the Adams County Medical Society, will hold a symposium on heart disease in Quincy on November 4.

Speakers on the afternoon program, starting at two o'clock at the Lincoln-Douglas Hotel, include Dr. Arthur Graham Asher of Kansas City, who will discuss nutrition and its relation to cardiac diseases, and Dr. Thomas H. Burford of St. Louis, Associate Professor of Surgery, Washington University

School of Medicine, on "Surgery in Congenital Heart Disease." There will be case presentations by Dr. Gordon Perisho and Dr. Eric Massig, Radiologist and Pathologist at Blessing and St. Mary's Hospitals, Quincy, followed by a panel discussion with Dr. Warren F. Pearce of Quincy as Moderator. Dr. George V. LeRoy, assistant professor of medicine, Northwestern University Medical School, will address the dinner meeting in the evening on "Coronary Heart Disease."

All physicians are invited to attend the symposium. There is no registration fee. Dr. Edward W. Cannady of East St. Louis is Chairman of the Illinois Heart Association's Educational Committee, with Dr. Warren F. Pearce of Quincy in charge of local arrangements.

Dr. Kobes Gets New Appointment.—Dr. Herbert R. Kobes, director of the University of Illinois' Division of Services for Crippled Children, has been appointed to the advisory committee of the U. S. Children's Bureau.

The appointment has been tendered to Dr. Kobes by Katherine F. Lenroot, chief of the U. S. Children's Bureau in the Federal Security Agency. She has announced plans for the committee to meet at least once a year to advise the Children's Bureau on matters relating to the extension and improvement of health services for mothers and children.

The committee is composed of individuals representing professional and citizen's groups and others selected by the Children's Bureau on the basis of their knowledge and interest in health services for mothers and children.

Promotions in Department of Welfare.—Dr. Paul E. Feldman, psychiatrist on the Manteno State Hospital staff, has been appointed assistant superintendent of Alton State Hospital, according to Cassius Poust, director of Illinois Department of Public Welfare.

Director Poust also announced that Dr. Joseph Albaum, staff physician at the Lincoln State School and Colony, has been promoted to the position of assistant superintendent there.

Dr. Feldman became a junior physician at Manteno in 1937 and in 1941, spent a year of study at the Institute for Juvenile Research in Chicago as a Fellow in psychiatry. He served as a psychiatrist in the Army in World War II and following his release in the grade of captain, returned to State service at Manteno.

Dr. Albaum went to Lincoln in 1938 as a junior physician, served as an Army medical corps captain for four years and following release, returned to his staff duties at Lincoln.

Statistical Summary for July 31, 1948.—The population present in all institutions of the State Department of Public Welfare July 31, 1948 was 46,496, an increase of 1,499 over July 31, 1947. On the books of all institutions including those present, in family care, paroled, escaped and all other absences were 53,431.

The greatest increase over July of last year was in the nine hospitals for mentally ill, the population of which rose 1,439. There were 1,221 admissions as compared to 1,028 in July, 1947. There were 745 discharges and 265 deaths during the month. In these hospitals there were 34,221 patients and a total of 37,447 on the books.

The institutions for mental defectives — Dixon State Hospital and Lincoln State School and Colony showed an increase of 218 over the previous year. The population present was 9,170 with 10,605 on the books.

There were 374 in Security Hospital, a decrease of 2 as compared to one year ago.

At Neuropsychiatric Institute, where most admissions are temporary for special treatment 65 patients were present July 31, 1948.

Clinics for trachoma control and prevention of blindness, in southern Illinois, provide treatment for trachoma, glaucoma and other eye diseases. During July, 236 received treatment for trachoma, 49 for glaucoma and 398 for other eye ailments. Twelve were hospitalized for operations.

The Chicago Community Clinic reported 608 interviews for the month. Five hundred and eighty-one were formerly patients in state hospitals, 257 at Elgin and 211 at Manteno.

The Eye and Ear Infirmary dispensary listed 18,401 treatments in July, and 401 persons were admitted to the hospital.

The Welfare Institutions reported 1,327 new cases and 5,496 old dental cases for July.

HEALTH DEPARTMENT ACTIVITIES

Dr. Herbolsheimer Given New Post.—Effective June 1, Dr. Henrietta Herbolsheimer has been appointed medical administrative assistant to Dr. Roland R. Cross, Illinois director of public health. She succeeds Dr. Leslie W. Knott who is now at work with the American Mission for aid to Greece at Athens. Mr. George K. Hendrix has been appointed chief of the division of Hospital Construction and Services, succeeding Dr. Herbolsheimer in that capacity.

Public Health Methods.—Frank C. Bauer has been appointed chief of the newly organized Public Health Methods Division of the Chicago Health Department which will collect and analyze Chicago Health Department birth, death, and disease statistics. Mr. Bauer was chief of the Import Statistics Section of the Bureau of Census in Washington from 1942-1947. Previously, he did statistical work for the Alien Registration Division of the Department of Justice and the Public Health Service.

Personal.—Dr. Max Igloe has been appointed in charge of the new district health center located at 800 South Paulina Street of the Chicago Department of Health.

Dr. Rawlings Named Chief of Maternal and Child Health.—Dr. Donaldson F. Rawlings has been appointed Chief of the Division of Maternal and Child Health of the Illinois Department of Public Health, effective July 6. He succeeds Dr. Ruth E. Dunham who resigned to accept a commission in the U. S. Public Health Service.

A native of Illinois, Dr. Rawlings graduated from the University of Chicago in 1936 and received his medical degree from Northwestern University Medical School in 1941. He also holds a master's degree in public health from Johns Hopkins University in Baltimore, Maryland.

With the exception of two years spent in the Medical Corps of the U. S. Naval Reserve, Dr. Rawlings has been employed continuously in public health work in Illinois since 1942. He served as Health Superintendent in District No. 4, with offices in Galesburg, and as Health Officer for the Lawrence County Defense Zone Health Department and for the Alexander-Pulaski Bi-County Health Department. At the time of his recent appointment Dr. Rawlings was serving as Assistant Chief of the Division of Local Health Administration of the State Department of Public Health.

Annual Report for Cook County.—A well illustrated booklet incorporates the activities of the Cook County Department of Public Health for the year 1947. The report states that in suburban Cook County there were no cases of smallpox and only one case of diphtheria. Whooping cough cases declined from 531 in 1946 to 461 in 1947; and typhoid fever cases from 7 in 1946 to 5 in 1947. No major epidemics occurred in Cook County. Isolation, quarantine and increasing emphasis on immunization of all infants are among the significant reasons for this reduction. Epidemiologic investigation and nursing and medical service was given to 2,476 communicable disease cases. Every case of an animal bite was investigated to determine the condition of the animal and whether the person bitten was under medical care. Of the 432 animal bites reported 49 animals were found to be rabid.

Recognizing that tuberculosis is the leading cause of death for people between the ages of 15 and 44, the Department carried on a concerted case finding program. During 1947, 351 cases were reported and 5,962 children were tuberculin tested.

During 1947, for the first time since the establishment of the County Health Department, no deaths occurred from infantile paralysis. There were 81 cases reported, however.

One of the most significant activities of the department is the life-saving work with premature infants. In Cook County about 5 per cent of the babies born alive are premature. A 24 hour service to save the lives of these infants has been inaugurated in cooperation with other agencies. The service is available to suburban hospitals and physicians by calling the County Sheriff's Police.

The report discusses the expanded services designed to improve the school health program, based on the Illinois Health and Physical Education Law. Nursing services were provided to 204 schools having an enrollment of 37,035. Physical examinations were completed on 9,195 elementary and high school students by health department physicians, cooperating pediatricians and local physicians.

The summary of activities of the Cook County Department of Public Health concludes with discussions on sanitary engineering and family health service, laying special emphasis on the administrative activities of the department.

The objectives of the Cook County Department of Public Health may be summed up in its slogan: Prevention Our Watchword; Cooperation Our Theme and Healthful Living Our Goal. William N. Erickson is president of the Board of Health of Cook County and Dr. Edward A. Piszczek, director of the department.

MARRIAGES

Dr. Richard J. Graff, Peoria State hospital superintendent, to Miss Myra White, Danville, on July 10, 1948.

DEATHS

Arthur Max Aszmann, East St. Louis, who graduated at The Hahnemann Medical College and Hospital in 1910, died suddenly of a heart attack, August 4, aged 62. He was a past president of the St. Clair County Medical Society.

Edward Paul Emerson, retired, Astoria, who graduated at Barnes Medical College, St. Louis, in 1898, died in St. Francis Hospital, Macomb, August 22, aged 65.

George Jacob Hinn, Highland Park, who graduated at Illinois Medical College in 1904, died in St. Francis Hospital, Evanston, August 8, aged 75.

Irwin Wilson Howard, Aurora, who graduated at Ohio Medical University, Columbus, in 1910, died August 1, aged 70.

Philip Daniel McGinnis, Joliet, who graduated at Rush Medical College in 1900, died April 18, aged 72, of uremia. He was past president of the Will Grundy County Medical Society.

John Edward McGuiggan, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died May 30, aged 56, of coronary thrombosis.

John Earle Meloy, Peoria, who graduated at the University of Illinois College of Medicine in 1900, died in Grand Rapids, Minn., August 4, aged 77.

Robert Bruce Preble, Chicago, who graduated at Northwestern University Medical School in 1891, died in St. Luke's Hospital, July 26, aged 82, of myocardial infarction, diabetes and third degree burns. He was professor of medicine at Northwestern University Medical School and was past president of the Chicago Medical Society and the Chicago

Heart Association. In April 1917 he was commissioned a major in the medical reserve corps; he served as chief of the hospital center at Mars Sur Alliers, France, and on Jan. 31, 1919, was discharged with the rank of lieutenant colonel.

Frances A. Ring, retired, Chicago, who graduated at Harvey Medical College, Chicago, in 1903, died August 20, aged 86. For several years she was physician in charge of the girls' department in the Juvenile Court.

Carl Gustaf Rydin, Chicago, who graduated at the University of Illinois College of Medicine in 1902, died July 30, aged 74.

Abraham W. Schram, Chicago, who graduated at Rush Medical College in 1896, died July 31, aged 73. He was a member of the American Association for the Study of Internal Secretions, and had practiced medicine in Chicago for 52 years.

Richard Wade Taylor, Villa Grove, who graduated at Chicago College of Medicine and Surgery in 1914, died August 20, aged 69. He was coroner for Douglas County.

Dr. Ollie Herbert Treadway, retired, Pittsfield, formerly of Virden, who graduated at University of Missouri School of Medicine in 1893, died July 14, aged 87.

William Osgood Tuck, retired, Plymouth, who graduated at Northwestern University Medical School in 1891, died August 21, aged 82. He had practiced medicine at Plymouth for more than 50 years.

Frederick H. Yates, retired, Decatur, who graduated at Barnes Medical College, St. Louis, in 1907, died August 19, aged 65. He had practiced medicine in St. Elmo until 1919 when he moved to Decatur.

George Guido Zohrlaut, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1902, died June 9, aged 69, of carcinoma of the bladder.

"FOR THE COMMON GOOD"

Public relations at work might well be the keynote of a compliment for the Woman's Auxiliary of the Sangamon County Medical Society during the State Fair in Springfield, August 13-22. In rotating teams, the Auxiliary staffed the Exhibit of the Illinois State Medical Society, answered numerous and varied questions and distributed thousands of copies of Health Talk, the Doctor and His Medical Society, the Illinois Prepayment Medical and Surgical Plan and Doctors and Horses.

Evidence that this type of activity is educational and of great interest to the Auxiliary members is reflected by individual women who had already worked one shift and requested that they be given another opportunity to return to the Booth.

In the words of Mrs. Walter Shriner, President of the Sangamon Auxiliary, this was a true opportunity to gauge the public's individual reactions and to set up a yardstick to determine the need for exploring new educational services. Mrs. Shriner believes that this one activity has resulted in more knowledge as well as enthusiasm on the part of her auxiliary.

Assisting Mrs. Shriner in staffing the exhibit were Mrs. Franz Fleischli, in charge of special projects for the auxiliary, Mrs. C. R. Dirskell, Mrs. E. L. McClay, Mrs. Floyd Barringer, Mrs. Robert Goodwin, Mrs. David McCarthy, Mrs. C. B. Stuart, Mrs. Henry Berchtold, Mrs. William Curtis, Mrs. H. H. Southwick, Mrs. S. R. Magill, Mrs. C. A. Ranker, Mrs. Richard Allyn, Mrs. Corwin Mayes, Mrs. A. T. Kwedar, Mrs. J. Hayden Shamel, Mrs. Paul LaFata.

Visitors at the Exhibit of the Illinois State Medical Society included, among many physicians of the Sangamon County Medical Society, Mr. Tom Hendricks, Secretary of the Council on Medical Service, AMA, and Mr. Lawrence Rember, director of Public Relations, AMA. In the Newsletter of the Council on Medical Service, Mr. Hendricks cited the query of the auxiliary member to Governor Warren of California: "I am the wife of a Springfield physician and would like to know your stand on socialized medicine." The governor replied that he was for prepayment medical care.

The cooperation of the Woman's auxiliary of the Sangamon County Medical Society is public relations as it should be practiced. They gave of themselves to the thousands of persons who visited the booth and told the story of the educational services available through the Illinois State Medical Society and maintained by the individual physician.

The Auxiliary is accorded the warm thanks of the Illinois State Medical Society for this excellent public relations effort. Acknowledgement also goes to Mr. Conrad Becker, Business Administrator of the Illinois State Fair. His courtesy in making available special passes to members of the Auxiliary is greatly appreciated.

To Dr. Roland R. Cross, state director of health, and members of his staff, the Society extends its

thanks. The space for the Exhibit, made available for the second consecutive year, was through the courtesy of the Illinois Department of Public Health. Special acknowledgement is given to Mrs. Margaret B. Cowdin, director, Bureau of Health Education, Mr. David V. Dahl, Exhibits Technician, and Mr. Forrest Nelson, assistant to Mrs. Cowdin. Their assistance is further proof of the close cooperation between the Illinois State Medical Society and the Illinois Department of Public Health.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society: Charles P. Blair, Monmouth, Chairman:

Harry Leichenger, Chicago, Mothers Club of the Washington Boulevard Methodist Church in Oak Park, September 21, Prevention of Childhood Diseases.

Carroll Birch, Chicago, Fullerton Business and Professional Woman's Club, in Chicago, October 13, Skin Deep — or Deeper. This is the inaugural lecture in a series of eight sponsored by this newly organized group.

Adrian D. M. Kraus, Chicago, Fort Dearborn PTA in Chicago, October 13, How the Parents of the School Can Make Our Health Program More Effective by Encouraging Protection through Immunization.

Franklin Fitch, Chicago, John Mills PTA, October 15, in Chicago, Problems of Sex Education. tion.

Mr. John W. Neal, Chicago, Lions Club in Chicago, October 27, on Socialized Medicine: Threshold of the Welfare State.

Beulah C. Bosselman, Chicago, Public Health Chairman of the Illinois Federation of Women's Clubs, November 8, in Chicago, Mental Hygiene as Applied to Everyday Living.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman:

John Soukup, Chicago, Henry County Medical Society in Kewanee, September 9, on The Pelvis in Obstetrics.

Norman L. Baker, Springfield, Greene County Medical Society in White Hall, September 10, Treatment of Fungus Infections of the Skin, illustrated.

B. C. Kilbourne, Chicago, Fulton County Medical Society in Canton, September 17, on Fractures of the Hand.

Harry M. Hedge and Harry A. Oberhelman, both of Chicago, Iowa and Illinois Central District Medical Association, in Rock Island, September 22, on "Cosmetics — Use and Abuse and Pediatric Surgery, respectively.

Archibald Hoyne, Chicago, Will-Grund County Medical Society, in Joliet, September 23, Diagnosis by Observation, illustrated.

Samuel Perlow, Chicago, Will-Grundy County Medical Society, in Joliet, October 14, on Varicose Veins, illustrated.

William H. Marlowe, Chicago, La Salle County Medical Society, in La Salle, October 14, Surgical Emergencies in Gallbladder Disease.

Alfred D. Biggs, Chicago, Effingham County Medical Society in Effingham, October 21, Respiratory Infections in Infancy and Childhood.

Thomas J. Coogan, Chicago, Logan County Medical Society in Lincoln, October 21, Diagnosis and Treatment of Coronary Thrombosis.

Herbert Rattner, Chicago, Will-Grundy County Medical Society in Joliet, October 28, on Common Diseases of the Skin, illustrated.

Edward L. Compere, Chicago, La Salle County Medical Society in La Salle, November 11, Differential Diagnosis and Treatment of Low Back Pain.

George V. LeRoy, Chicago, Kankakee County Medical Society, in Kankakee, November 12, on Current Views on the Treatment of Leukemias.

James T. Jenkins, Peoria, Logan County Medical Society in Lincoln, November 18, Anorectal Pathology, kodachromes.

William B. Serbin, Chicago, Effingham County Medical Society, in Effingham, November 18, Indications for and Methods of Induction of Labor.

James H. Hutton, Chicago, DeKalb County Medical Society in Sycamore, November 23, Hypertension: Its Diagnosis and Treatment from an Endocrine Standpoint.

Herbert E. Schmitz, Chicago, McDonough County Medical Society in Macomb, November 26, Menstrual Irregularities and Abnormalities with Special Attention to their Occurrence in Younger Women.

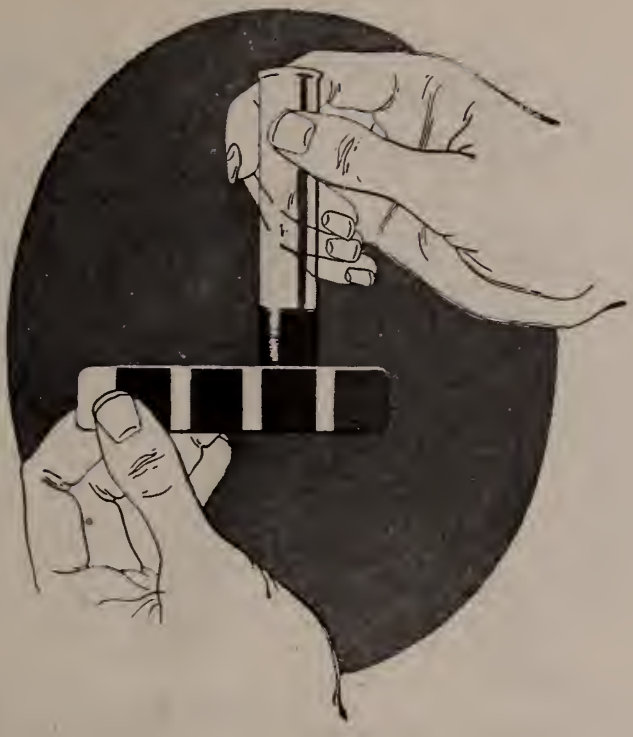


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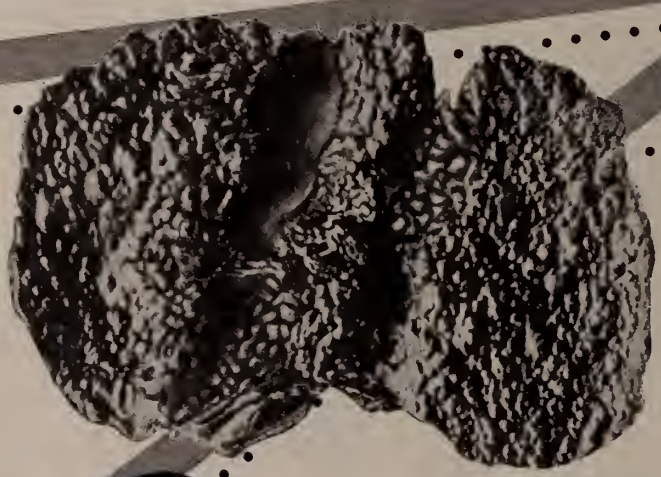
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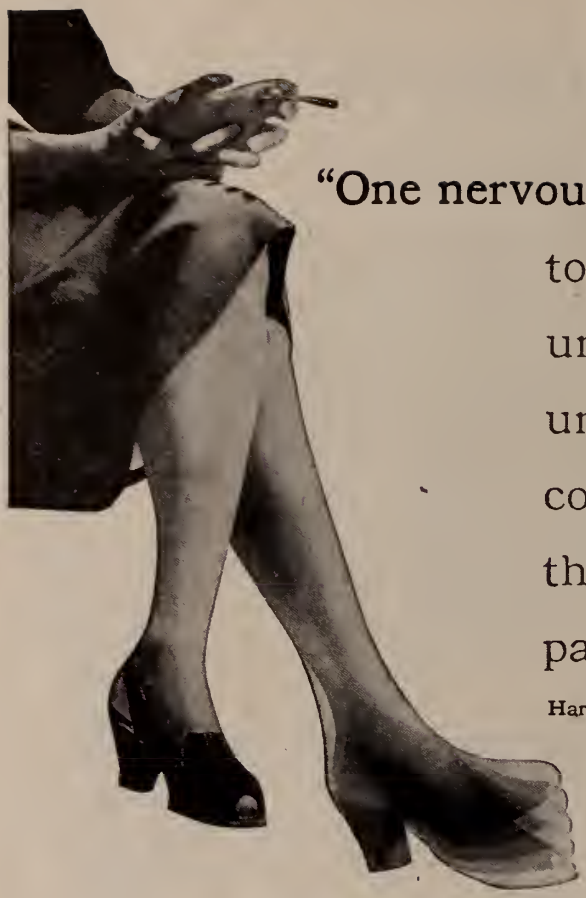
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***Reprints on Request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.



"One nervous woman can give rise to more diverse, undiagnosed and undiagnosable complaints than a whole pathological ward."

Harding, T.S.: M. Rec. 160:198, 1947

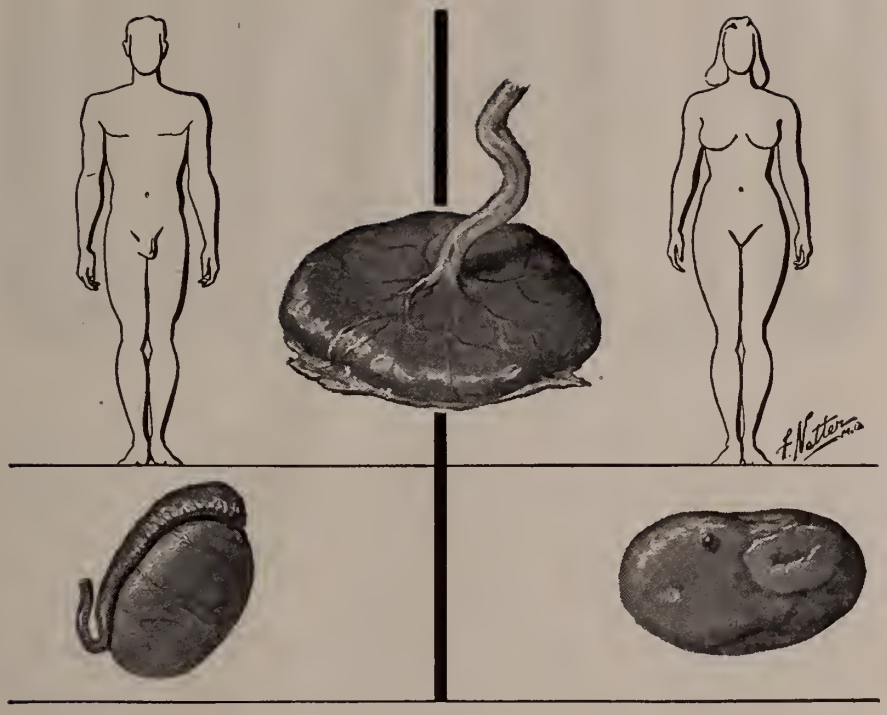
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1. Scudi, J. V., and Duca, C. J.: J. Urol. (to be published).
2. Carroll, G., and Allen, H. N.: J. Urol. 55: 674 (1946)

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PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER



SYMPOSIUM ON LOW BACK PAIN

James L. Hamner, M.D., Editor, Mannboro, Va. In SOUTHERN MEDICINE AND SURGERY. July, 1948. Volume 110, No. 7, Page 209.

The commonest cause of persistent lumbosacral pain is degeneration or traumatic injury of the intervertebral disc.

The diagnosis of herniated disc depends on study of the history of the case, upon evaluation of the symptoms, and upon the result of a neurological examination for areas of hypalgesia and alteration of the knee and ankle jerks.

Treatment of acute low-back strain consists primarily of rest and graduated physical activity on a semi-rigid mattress. Any flexion contracture of the hips suggests the addition of flexion of the knees to flatten lumbar lordois; this may be added to any strain for comfort. Rest on either side in similar position is allowed if comfortable. A strain having no nerve symptoms is seldom improved by leg traction. Diathermy, infrared radiation or hot packs afford relief and shorten convalescence. When improvement justifies change to ambulatory treatment, support by adhesive strapping or corset is added. Activity is restricted for at least three months.

Of particular importance is the equalization of leg length by shoe elevation. Minor shortening of a leg is common and causes little difficulty. The addition of a strain in the low-back area to leg-length is prone to cause symptoms.

Under certain conditions as in pregnancy, obesity, muscular weakness or bone deficiency, the line of gravity is moved posterior to the sacroiliac joint and balance of the body is then possible only by excessive muscular effort or by accentuating the lumbar lordosis with secondary increase in the angle of pelvic inclination, a flexed position of the hips and dorsal kyphosis. In strain of the low-back structures, posture improvement will contribute greatly to clinical improvement. This improvement follows the use of supports to decrease abdominal prominence of lumbar lordosis and the medical treatment of the underlying general deficiency.

A STUDY OF PHYSICAL ACTIVITY IN JUVENILE DIABETIC PATIENTS

Robert L. Jackson, M.D., and Helen G. Kelly, M.S., Iowa City, Iowa. THE JOURNAL OF PEDIATRICS. Vol. 33. Page 155. August, 1948.

Exercise was known to be an important factor in the treatment of diabetes mellitus long before the discovery of insulin. Since the discovery of insulin and the advances made in its refinement and modification, along with the recent rapid advances in our knowledge of nutrition, exercise as a factor in the treatment of diabetic patients has received little attention.

In 1940 the method was described by this

(Continued on page 48)

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Would You Use a Screen to Collect Dust?

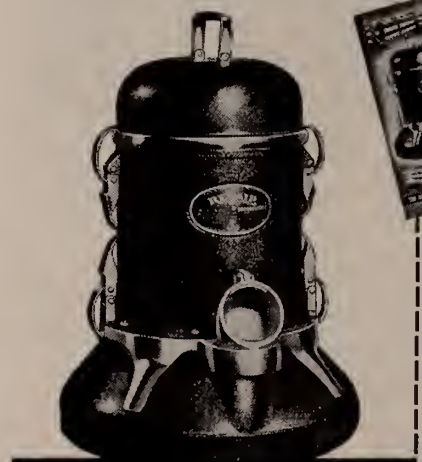


Of course you wouldn't collect dust in a screen. If you did, fine dust would filter through the holes of the screen, back into the air and onto the surfaces you had just cleaned.

Using a bag or filter to collect dust is like gathering dust in a screen. The bag must be porous to let the air escape. When the air escapes, dust escapes with it. You actually take dust from the floor and throw it into the air you breathe!

Rexair, the new home appliance, solves this problem by collecting dust in water instead of a bag. Rexair takes dust wherever it is found—on rugs, bare floors, upholstery, furniture, drapes—and traps it in a water bath. Rexair even takes dust from the air you breathe.

Wet dust cannot fly, and dust cannot escape from Rexair's water basin. You simply pour the water down the drain, and dirt goes with it—out of your house forever.





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When age, disease or any injurious stimuli cause problems in protein supplementation, many physicians now prescribe Swift's Strained Meats. An excellent, palatable source of complete, high-quality proteins, Swift's Strained Meats provide *all* the essential amino acids *simultaneously*—for optimum protein synthesis.

Swift's Strained Meats supply goodly amounts of natural B vitamins, iron and trace minerals and are low in fat content.

Originally developed for infant feeding, these meats are strained fine—may easily be used in tube-feeding, or for oral feeding in soft diets. Since salt content of the meats is at a minimum for infants, additional salting is suggested for adult usage. Convenient—ready to heat and serve. Six kinds of Swift's Strained Meats: beef, lamb, pork, veal, liver and heart, provide variety and tempting meat flavors that help combat anorexia. 3½ ounces per tin.

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Physical Medicine (Continued)

clinic for stabilization of children with diabetes mellitus. The regimen outlined has been effective, and a large number of children have been able to maintain excellent regulation over extended periods of time.

In our study of exercise under home regulation, we have limited our evaluation to the well-regulated patients because these subjects generally keep better records than those who maintain a lower level of diabetic control. It is obvious that a well-kept record is essential when the relation of exercise to diabetic regulation is being studied.

Presumably when the well-regulated diabetic child exercises more than usual, he utilizes his glucose directly for energy, and consequently, he has an excess of insulin available to convert glucose into glycogen. The loss of glucose from the blood, both by utilization and storage, easily may result in hypoglycemia. If the patient has mild diabetes mellitus requiring only a small amount of exogenous insulin, his ability to compensate will be enhanced by the depression of the endogenous insulin. On the other hand if the disease is severe, requiring a large amount of exogenous insulin, the patient will have a smaller threshold of safety.

It has been observed that if the diabetes of the child is well regulated and he maintains good control, later when he becomes more mature physically and mentally he is freer from shocks of all types. The adolescent or young adult learns to judge his tolerance for exercise and his need to compensate by eating extra food for unusual periods of strenuous exercise. However, the adolescent must be advised when and how much extra food he needs, in order to prevent erratic and excessive compensation and poor dietary habits. It is preferable that extra food be eaten at mealtimes. For the young adult, the privilege of eating socially after an evening party, dance, or game has psychologic and social advantages and is provided for in our regimen.

PREVENTIVE ORTHOPEDICS IN THE TREATMENT OF POLIOMYELITIS

John F. Pohl, M.D. THE JOURNAL OF PEDIATRICS. Vol. 33. Page 208. (August) 1948.

The general plan of management which was carried out in 1946, as in previous years, was to hospitalize every patient until spasm and muscle

(*Continued on page* 50)

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Physical Medicine (Continued)

shortening had been overcome and each patient had also been retrained as thoroughly as possible in the normal motor patterns. Treatment of the peripheral tissues consisted primarily of complete rest in bed with prompt and intensive application of moist heat to all areas affected by spasm. As pain and sensitivity disappeared, gentle manipulation and manual release of the shortened tissues was used where necessary in conjunction with the moist heat. Incipient deformities from muscle shortening responded to this treatment as spasm was overcome.

The period of hospitalization of the 1,057 surviving patients of the 1946 epidemic averaged twenty-one days for the thirty-three patients with abortive cases (those with clinical symptoms other than paralysis, but having a normal spinal fluid cell count); twenty-three days for the 356 nonparalytic patients; and will average from two to fourteen months for the paralytic patients, depending upon the severity of attack. It is estimated that nine patients will require a stay of two years.

STUDIES IN ELECTRONARCOSIS THERAPY 1. CLINICAL EVALUATION

Karl M. Bowman, M.D. and Alexander Simon, M.D.

In THE AMERICAN JOURNAL OF PSYCHIATRY, July 1948, Vol. 105, No. 1, Page 15.

SUMMARY

1. Electronarcosis has been administered to a group of 53 mentally ill persons. The results of follow-up studies one month after treatment was completed may be summarized as follows: 37 cases of schizophrenia were treated, 7 recovered; 9 cases of psychoneurosis were treated, none recovered; 7 cases of manic-depressive psychosis were treated, 2 recovered. However, if one includes only cases that received 7 or more treatments, the results one month after treatment would read as follows: 31 cases of schizophrenia were treated, 5 recovered; 5 cases of psychoneurosis were treated, none recovered; 4 cases of manic-depressive psychosis were treated, 1 recovered.

2. Of the 5 schizophrenic patients who received 7 or more treatments and recovered, improvement was noted at some time between the second to seventh treatment.

(*Continued on page* 54)



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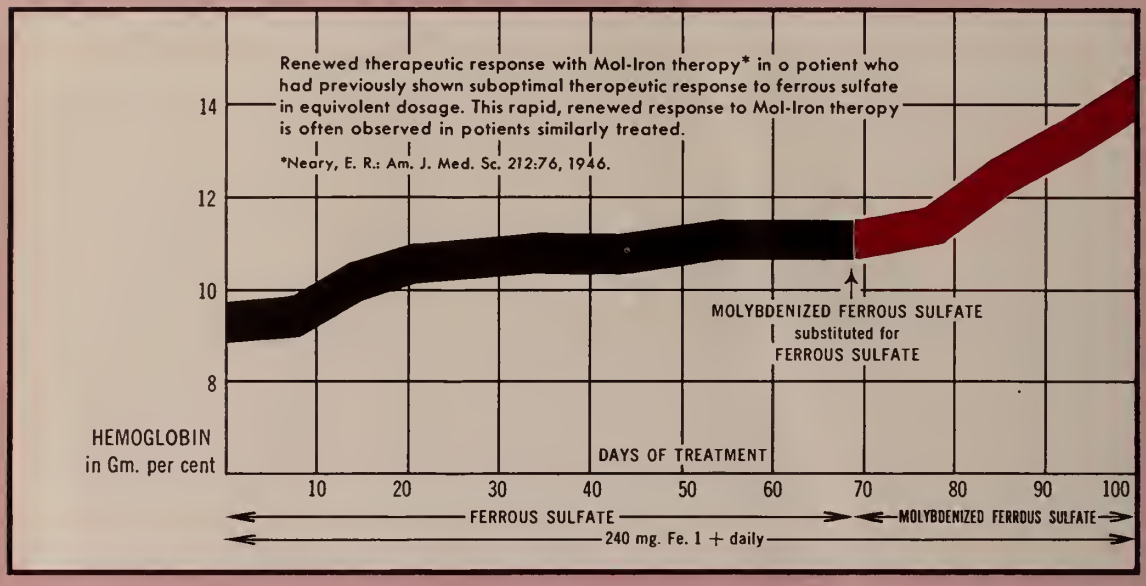
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1. Heoly, J. C.: Hypochromic Anemia: Treatment with Molybdenum-Iron Complex, Journal-Lancet 66:218 (July) 1946.
2. Kelly, H. T.: Gastro-Intestinal Intolerance to Orally Administered Iron, Penn. Med. J. 51:999 (June) 1948.

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Physical Medicine (Continued)

3. It is our impression that electronareosis is of no value in the treatment of psycho-neuroties, is certainly no better than electro-shock in treating the manie-depressive psychoses, and is equal to electroshock in the treatment of schizophrenia. Our series are too small for any definite eonelusions to be drawn, and the above estimation of the value of eleetronarcosis therapy is subject to revision after we have treated a larger series of cases.

4. Fractures of the spine occured in 15 of the 53 patients treated, amounting to 28.3% of the cases. This percentage can be greatly reduced by the use of sodium amytal or by the new Glissando teehnique reeently developed by Tietz.

5. Beeause of the extreme rise in blood pressure that oecurs during treatment, eleetronareosis should not be used on patients with hypertension or eardiac disease.

6. Electronarcosis is a more dangerous treatment than electroshock and is less simple to administer.

EFFECT OF DELAY OF INNERVATION ON RECOVERY OF MUSCLE AFTER NERVE LESIONS

E. Gutmann. Department for Research on Nervous System, University of Prague, Czechoslovakia. JOURNAL OF NEUROPHYSIOLOGY. Vol. XI: 279. July 1948.

Nerve suture following peripheral nerve injury in man is performed at various periods after injury.

It is concluded that up to a period of eight months of denervation, the poor degree of funetional recovery followin reinnervation is due to deficient maturation of the nerve fibers and to defieiency of the newly formed contact between nerve and musele fibers. The rate of regeneration of nerve fibers is apparently not affected after sueh periods of denervation. After longer periods, recovery of muscle fibers becomes more deficient, the degree of muscle atrophy being then apparently a decisive faetor in limiting funetional recovery.

It has been recognized for many years that the prevalence of tuberculosis among mentally ill patients is exceedingly high. A. H. Russakoff, M. D., Am. Rev. Tuberc., Jan., 1947.

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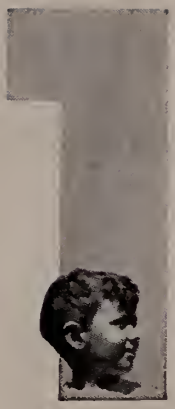
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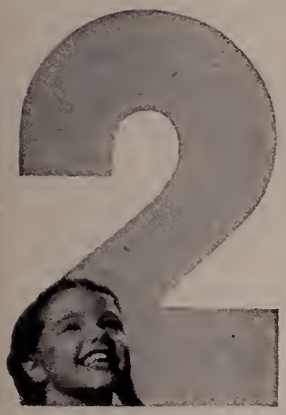
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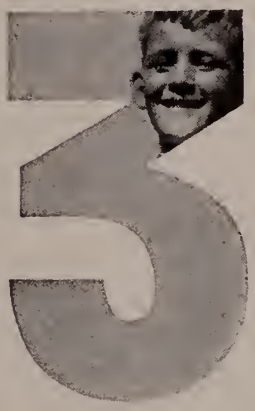
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BOOK REVIEWS



DIABETES MELLITUS IN GENERAL PRACTICE: By Arthur R. Colwell, M.D., Associate Professor of Medicine and Director of Medical Specialty Training, Northwestern University Medical School; Attending Physician, Evanston Hospital, Evanston, Ill.; Consulting Physician, Wesley Memorial Hospital, Chicago. The Year Book Publishers, Inc., Chicago, 1948. Price $5.25.

Treatment of diabetes mellitus is an urgent and very important medical problem. A condensation of the current knowledge and its practical application is always a welcomed matter. Such is the content of this manual which covers the field of diabetes in a limited, yet informative manner. The author has kept the facilities of the average physician in mind in his outline of the average diabetic patient. He stresses the differentiation between non-diabetic and diabetic glycosuria. About three-fourths of the book is devoted to treatment and the acute and chronic complications. As a handy, desk-copy reference, this should be a useful guide.

J.W.F.

MEDICINE: By A. E. Clark-Kennedy, M.D., F.R.C.P., Fellow of Corpus Christi College, Cambridge; Physician to the London Hospital and Dean of the Medical School. Volume I. "The Patient and His Disease." The Williams and Wilkins Company, 1947. Baltimore. Price $6.00. 383 pages.

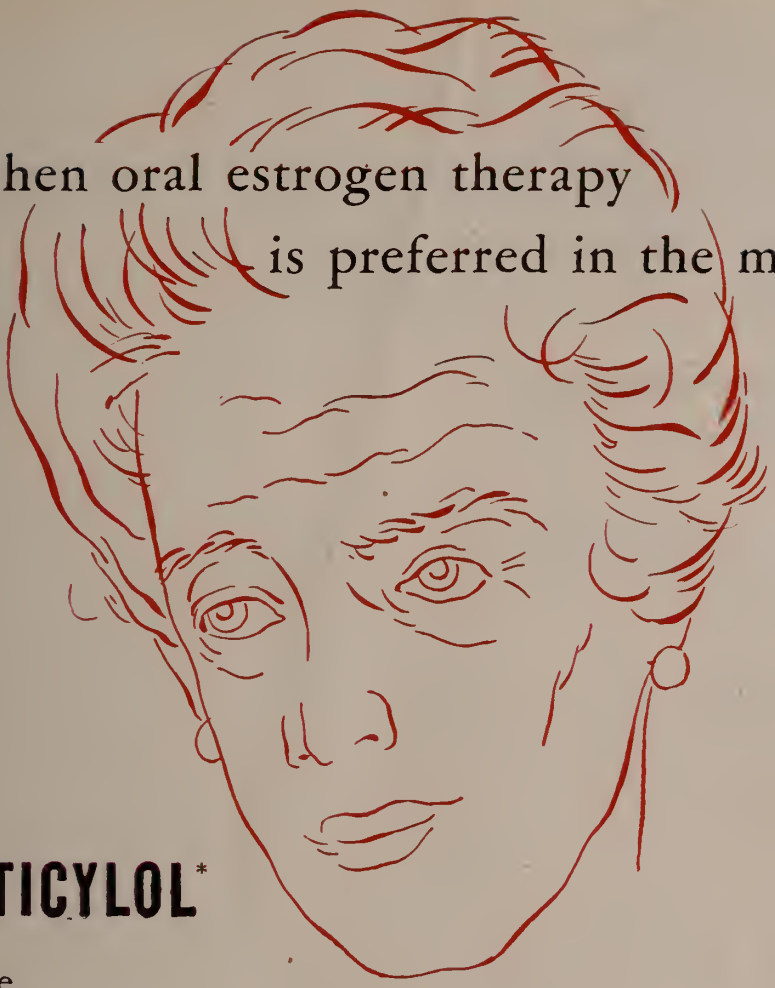
This book, written by an English physician, was prepared as a correlation of almost every aspect of medicine. This would assume a Herculean task and the author appears to have become lost in this endeavor. He prefaces his book by admitting his unfamiliarity with some of his subjects, but feels that he must never-the-less carry out the proposed theme. There is no organization of material. Most subjects and thoughts are discussed at random with inclusion of atomics, philosophy, genetics, psychiatry, medicine, surgery, and fact and fantasy. There is little to commend this book when it is compared with the usual medical publications. The author concludes with his apology.

J.W.F.

A HISTORY OF THE HEART AND THE CIRCULATION: by Frederick A. Willius, M. D., M.S. in Med. Senior Consultant in Cardiology, Mayo Clinic; Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Thomas J. Dry, M.A., M.B., CH.B., M.S. in Med., Consultant, Section on Cardiology, Mayo Clinic; Associate Professor Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. W. B. Saunders Company, Philadelphia and London 1948. Illustrated. Price $8.00, 456 pages.

An interesting presentation of a special part of medical history, the heart and the circulation, has been written by two prominent cardiologists. The authors trace their history from early scientific writings from the time of 4000 to 3000 B.C., available from translations of unearthed documents, to historical sketches of modern contributors. The effect of thought upon one generation to another is interestingly carried through. Galen lived in 138-201 A.D., and yet some of his concepts persisted for many centuries. Heated clashes occurred between later scientists in their acceptance or rejection of Galenic teachings. To such an extent was the art of observation, that, long before scientific explanation was forthcoming, there were written clinical descriptions which have been little improved upon today.

(*Continued on page* 60)



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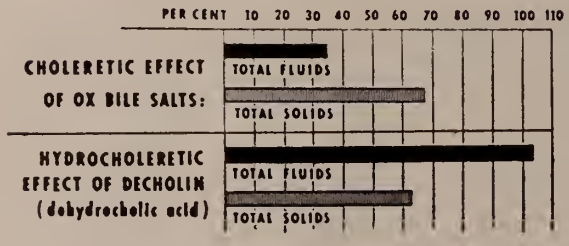
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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Book Reviews (Continued)

The authors have quoted directly from several of these writings. The rise of several European centers of medical thought gained great impetus during the 19th century. American medical education was not considered complete unless studies were pursued in Europe. Besides the major contributors to our knowledge, there were many relatively unknown scientists who introduced one or more important concepts in medicine. Although many of the ideas were erroneous, they were steps in advancement. Primarily dealing with historical development of knowledge of the cardiovascular system, general medical and surgical concepts are interwoven throughout the book. A book of this sort should be of interest to most any physician.

J.W.F.

SYNOPSIS OF PEDIATRICS: By John Zahorsky, A.B., M.D., F.A.C.P., Professor of Pediatrics and Director of the Department of Pediatrics, St. Louis University School of Medicine, and Pediatrician-in-Chief to the St. Mary's Group of Hospitals; Fellow of the American Academy of Pediatrics. Assisted by T. S. Zahorsky, B.S., M.D., Senior Instructor in Pediatrics, St. Louis University School of Medicine, and Assistant Pediatrician to the St. Mary's Group of Hospitals. Fifth edition. With 158 Text illustrations and 9 color plates. St. Louis The C. F. Mosby Company 1948. Price $5.50. 449 Pages.

This synopsis serves a useful purpose as a condensation of the voluminous literature in pediatrics, and offers a brief review in differential diagnosis. A book of this sort, however, can hardly be used with any authoritativeness for several reasons. Discussions of most subjects are too brief, usually confined to a short paragraph or two. Sentences are often so condensed that a full appreciation of their importance is lost, especially in diagnosis and treatment. It is not possible to present much of a clinical picture which means so much in clinical practice. On the other hand, the book is commendable for the purpose for which it was written and will be found particularly useful to the student. J. W. F.

CLINICAL OPHTHALMOLOGY FOR GENERAL PRACTITIONERS AND STUDENTS by H. M. Traquair, M.D., F.A.C.S., Ed., Consulting Ophthalmic Surgeon, Royal Infirmary, Edinburgh; Ophthalmic Surgeon, Chalmers Hospital, Edinburgh; Oculist to the Edinburgh Municipal Hospitals; Late lecturer on Diseases of the Eye, Edinburgh University. With 72 illustrations, including 8 coloured plates. St. Louis: The C. V. Mosby Company, Published 1948. Price $9.00.

This book presents ophthalmology with a view toward advising the general practitioner regarding the care of ophthalmic patients rather than teaching the details of ophthalmology.

Along with certain other procedures requiring special training, the examination of the ocular fundus has been omitted.

Complaints and symptoms of the patient are given a primary role in arriving at a conclusion, and the findings of a skilled examination are given a relatively secondary place.

The chapter dealing with impairment of sight without external signs contains a useful one page arrangement of the relationship of the age of the patient to the various features of a visual defect. This is followed with several pages of discussion of the conditions mentioned.

Another interesting, but short, chapter concerns misconceptions and prejudices in connection with eyesight.

Doctor Traquair, or should one say Mr. Traquair, Surgeon, has produced an interesting text about ophthalmology and in writing it aimed directly and well for the benefit of undergraduates and general practitioners.

L. P. A. S.

HANDBOOK OF OPHTHALMOLOGY by Everett L. Goar, A.B., M.D., F.A.C.S., Professor of Ophthalmology, Baylor University College of Medicine, Houston, Texas. With 48 Text Illustrations and 7 Color Plates. St. Louis: The C. V. Mosby Company. 1948. Price $5.50.

This book has been prepared from lectures given by the author to the junior medical students at Baylor University. It briefly reviews ophthalmology in 166 pages.

There is a short history of this branch of medicine which closes stating "We have better teaching facilities in this country now than they ever had in Europe."

Anatomy, embryology, physiology, methods and instruments of examination, and diseases of the lids, the orbit and the eyeball are summarized.

It is believed that in seeking brevity and in keeping the textbook elementary Doctor Goar has been forced to remain more superficial than is compatible with usefulness.

L. P. A. S.

EMOTIONAL MATURITY: Development and Dynamics of Personality; Leon J. Saul, M.A., M.D., J. B. Lippincott Company, Philadelphia; 1947. Price $5.00.

The author has endeavored in this interesting book to show that the field of psychiatry is concerned with many problems of behavior in human beings other than the various forms of insanity. It deals with the conflict of the feelings and desires of individuals who are seen daily in the offices of physicians everywhere.

Emotional development and the many factors which affect human behavior are indeed well presented in the book, and it should be of much value to any who deal with people. As the author states, the book was evolved mostly from teaching notes, and is well fortified with many case reports which add materially to its interest.

The effect of heredity as well as environment are well brought out in regard to their subsequent relationship with disturbed emotional stability.

The book is well organized, even though the author admits that it is a "catch as catch can" affair, and lacks continuity and perfection of form that would be de-

(*Continued on page* 63)



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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Coca Cola, Atlanta, Ga. 63
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Libby, McNeil & Libby, Chicago 9
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover
National Dairy Products, New York, N. Y.
Nestle's Milk Products, Inc., 155 E. 44th St., New York 17
Swift & Co., Chicago 47
Wander Company, 360 N. Michigan Ave., Chicago

FINANCIAL AND INSURANCE

Medical Protective Co., Fort Wayne, Ind. 18
Physician Casualty Co., Omaha, Neb. 48

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 25
Ames Co., Inc., Elkhart, Ind. 60, 61
Arlington Chemical Co., Yonkers 1, N. Y. 9
Armour Laboratories, Chicago 9, Ill. 41
Ayerst, McKenna & Harrison Ltd., New York 16 31
Baybank Pharmaceuticals, New York 4
Borcherdt Malt Extract Co., Chicago 12, Ill.
Bristol Laboratories, Inc., Syracuse 1, N. Y. 32
Bristol-Meyers Co., New York
Ciba Company, Summit, N. J. 4, 59
Commercial Solvents Corp., Terre Haute, Ind. 3, 38
Crookes Laboratories, Inc., 305 E. 45th St., N. Y.
Doho Chemical Corp., New York 13, N. Y. 55
Durex Products, New York
Endo Products, Inc., Richmond Hill 18, N. Y.
Otis E. Glidden & Co., Evanston
Gold Pharmacal Co., New York 67
Hoffman-LaRoche, Inc., Nutley, N. J. 12
Holland-Rantos Co., Inc., 551 Fifth Ave., New York
Homemakers' Products Corp., New York 10, N. Y. 29
Hoosier Pharmacal Co., Indianapolis, Ind.
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 50
Interchemical Corp., Union, New Jersey
International Pharmaceutical Corp., Boston 16
International Vitamin Corp., 50 E. 42nd St., New York City
Irwin, Neisler & Co., Decatur, Ill.
E. E. Kunze, Inc., Milwaukee 4 11
Lanteen Medical Laboratories, Chicago 10 22
Thos. Leeming Co., 155 E. 44th St., New York 17
Lily, Eli & Co., Indianapolis, Ind. 35, 36, 37
Maltbie Chemical Co., Newark, N. J.
S. E. Massengill Co., Bristol, Tenn. 26
McNeil Laboratories, Inc., Philadelphia, Pa.
Merck & Co., Rahway, N. J. 28
Morris, Philip & Co., 119 Fifth Ave., New York 39
Nepera Chemical, Yonkers, N. Y. 43
Num Specialty Co., Pittsburgh, Pa. 66
Parke, Davis & Co., Detroit, Mich. 13
Plastishield, Inc., Minneapolis 2, Minn. 34
Rare Chemicals, Inc., Flemington, N. J.
Reed & Carnrick, Jersey City 6, N. J.
Rees Davis Drugs, Meridan, Conn.
Reynolds & Co., R. J., Winston-Salem, N. C. 21
Roche-Organon, Inc., Nutley, N. J. 33
J. B. Roerig & Co., 536 Lake Shore Drive, Chicago
Sandoz Pharmaceuticals, New York 14 10
Schenley Laboratories, Inc., N. Y. 1, N. Y. 24
Schering Corp., Bloomfield, N. J. 23
Schmid, Julius, Inc., 423 W. 55th St., New York City .. 45
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, 11 Canal St., Chicago 27
The Smith Dorsey Co., Lincoln, Nebr. 17
Smith, Kline & French, Philadelphia 6, 30, 40, 57
E. R. Squibbs & Co. 15
The Tarbonis Co., Cleveland 3, Ohio 53
Upjohn Co., Kalamazoo, Mich. 56
Walker Vitamin Products, Inc., New York 42
Wm. R. Warner & Co., 113 W. 18th St., New York .. 14
Warren-Teed Products Co., Columbus 8, Ohio
Whittaker Laboratories Inc., New York City 5
White Laboratories, Inc. 19, 20, 51, 52
Winthrop Stearns Co., 70 Varick St., New York 49
Wyeth Incorporated 16
Zemmer Co., Pittsburgh, Pa.

SANATORIA AND SANITARIA

The Bellevue Place, Batavia, Ill. 68
Costeff Sanatorium, Peoria, Ill. 66
Douglas Park Hospital, Chicago 65
Edward Sanatorium, Naperville, Ill. 64
Michell Farm, Peoria 65
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 64
North Shore Health Resort, Winnetka 66
Mary Pogue School, Wheaton, Ill. 67
Stokes Sanitarium, Louisville, Ky. 68

SCHOOLS

Washington University, St. Louis 10 5

EQUIPMENT

General Electric X-Ray Corp., 2012 W. Jackson Blvd., Chicago
Picker X-Ray, New York 10, N. Y.
Rexair, Toledo, Ohio 46

RADIUM

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 65
Physicians Radium Assn., 55 E. Washington St., Chicago 48
Radium & Radon Corp., Chicago 2 54

Book Reviews (Continued)

sirable. The book is divided into four parts:

The Achievement of Maturity

Emotional Forces in the Development of Personality

The Nature of Neurosis

The Dynamics of Personality

As would be expected in such a book, a chapter is devoted to sexuality, in which many interesting reports are given to show reasons for the various types of reactions and thought on the part of different individuals. Heredity and environmental factors are shown in these discussions in a most interesting manner.

The book should be of material interest to physicians, whether or not they are interested in psychiatry, and also to others who in their various fields of endeavor are interested in the important subjects of human relations and emotional maturity.

DISEASES OF THE NOSE, THROAT AND EAR by William Lincoln Ballenger, M.D., F.A.C.S., Late Professor, School of Medicine, University of Illinois, Chicago, and Howard Charles Ballenger, M.D., F.A.C.S., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern School of Medicine, Chicago, Surgeon Department of Otolaryngology, Evanston Hospital, Evanston, Illinois, assisted by John Jacob Ballenger, B.S., M.D., Research Fellow in Otolaryngology, Northwestern University School of Medicine, Chicago. Ninth edition, thoroughly revised, with 597 illustrations and 16 plates. Lea and Febiger, Philadelphia. Published 1947. Price $12.50.

This excellent text and reference book of nearly 1000 pages has been carefully revised to bring it up to date by Doctor H. C. Ballenger, assisted by Doctor J. J. Ballenger, in collaboration with Doctors J. D. Kelly, Alfred Lewy, Gabriel Tucker and Chevalier L. Jackson.

There has been some rearrangement and rewriting, an appreciable amount of deletion of obsolete matter and the addition of considerable current material. Many of the illustrations are new in this revision, either as replacements or as fresh additions. An entirely new chapter on headaches and neuralgias of the face and head is very much worth while.

Anatomy, physiology and therapy — both medical and surgical, as related to otolaryngology are presented in an easily read completeness. Rhinoplastic reconstruction is fully covered.

The chapters on bronchoscopy, direct laryngoscopy, esophagoscopy and gastroscopy are preceded by a chapter entitled "The Bronchologic Clinic" which discusses the background for success in the diagnosis and treatment of pathology in the air and food passages.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE TREATMENT OF MALIGNANT DISEASE BY RADIUM AND X-RAYS: By Ralston Paterson, M.C., M.D., F.R.C.S.E., D.M.R.E., F.F.R., Christie Hospital and Holt Radium Institute, Manchester: The Williams & Wilkins Company, Baltimore, 1948. 621 pages. $11.00.

MEDICAL WRITING, The Technic and the Art: Morris Fishbein, M.D., Editor, The Journal of the American Medical Association. With the assistance of Jewel F. Whelan, Assistant to the Editor. Second Edition. The Blakiston Company, 1012 Walnut Street, Philadelphia 5, Pa., and Toronto, Canada. Published July 2, 1948. 292 pages. 36 illustrations. $4.00.

PREOPERATIVE AND POSTOPERATIVE CARE OF SURGICAL PATIENTS: Hugh C. Ilgenfritz, A.B., M.D., F.A.C.S., Formerly Assistant Professor of Surgery, Louisiana State University School of Medicine, and Visiting Surgeon, Charity Hospital of Louisiana at New Orleans. The C. V. Mosby Company, St. Louis, 1948. 898 pages. 110 illustrations. $10.00.

MORE THAN ARMIES: The Story of Edward H. Cary, M.D.: By Booth Mooney, with an introduction by Dr. Morris Fishbein; Mathis, Van Nort & Company, Dallas, Texas. 270 pages. $5.00.

TEXTBOOK OF CHIROPODY: Margaret J. McKenzie Swanson, B. Litt., F. Ch. S., Co-founder of Edinburgh Foot Clinic and School of Chiropody; formerly Senior Lecturer in Chiropody and Therapeutics and Senior Clinical Teacher in Edinburgh School of Chiropody; Member of Fellowship Examining Board of the Society of Chiropodists. The Williams and Wilkins Company, Baltimore, 1948. 212 pages. 168 illustrations. $5.00.

AN INDEX OF TREATMENT by Various Writers. Edited by Sir Robert Hutchison, Bt., M.D., L.L.D., F.R.C.P., Consulting Physician, London Hospital and Hospital for Sick Children, Great Ormond Street, assisted by Reginald Hilton, M.A., M.D., F.R.C.P., Physician to St. Thomas's Hospital; Consulting Physician, Epsom Hospital; Consulting Physician and Cardiologist, Wembley Hospital. Thirteenth Edition, Revised. The Williams and Wilkins Company, Baltimore, 1948. 972 pages. $17.00.

TEXTBOOK OF SURGICAL TREATMENT INCLUDING OPERATIVE SURGERY: Edited by C. F. W. Illingworth, C.B.E., M.D., Ch.M., F.R.C.S.E., Regius Professor of Surgery, University of Glasgow. Compiled by twenty-one contributors. Third Edition. The Williams and Wilkins Company, Baltimore, 1947. 644 pages. $10.00.

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BACTERIAL AND VIRUS DISEASES — Antisera, Toxoids, Vaccines and Tuberculins in Prophylaxis and Treatment. H. J. Parish, M.D., F.R.C.P.E., D.P.H., Clinical Research Director, Wellcome Foundation Ltd; formerly Bacteriologist, Wellcome Physiological Research Laboratories. The Williams and Wilkins Company, Baltimore, 1948. 168 pages. $2.75.

PSYCHIATRY, A Short Treatise: William A. O'Connor, L.M.S.S.A. (Lond.); D.P.M. (Lond.) Medical Superintendent, Ashwood House, Kingswinford, Staffs, late Assistant Medical Officer, Maudsley Hospital; Tutor (Psychology) of Extra-Mural, University, and W. E. A. Classes. The Williams and Wilkins Company, Baltimore, 1948. 380 pages. $9.00.

MICROBIOLOGY AND PATHOLOGY: By Charles F. Carter, B.S., M.D., Instructor in Pathology and Applied Microbiology, Parkland Hospital School of Nursing, Dallas, Texas; Director, Carter's Clinical Laboratory, Dallas, Texas; Consulting Pathologist, St. Louis Southwestern Railway Hospital, Texarkana, Arkansas; Consulting Pathologist, Mother Frances Hospital, Tyler, Texas; Formerly Director of Laboratories, Parkland Hospital. The C. V. Mosby Company, St. Louis, 1948. 845 pages, with 216 illustrations and 25 color plates. Fourth Edition. $5.00.

HANDBOOK OF ORTHOPAEDIC SURGERY: Alfred Rives Shands, Jr., B.A., M.D., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation, Wilmington, Delaware; Visiting Professor of Orthopaedic Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. In collaboration with Richard Beverly Raney, B.A., M.D., Associate in Orthopaedic Surgery, Duke University School of Medicine, Durham, North Carolina; Lecturer in Orthopaedic Surgery, University of North Carolina School of Medicine, Chapel Hill, North Carolina. Illustrated by Jack Bonacker Wilson. Third edition. The C. V. Mosby Company, St. Louis, 1948. 574 pages. 159 illustrations. $6.00.

CANCER MANUAL: Standards for the Diagnosis and Treatment of Cancer. By The Cancer Committee of the Iowa State Medical Society. Athens Press, Iowa City, Iowa. 160 pages. $1.00.

ESSENTIALS OF PATHOLOGY, *3rd Edition*: Lawrence W. Smith, M.D., F.C.A.P., formerly professor of Pathology, Temple University School of Medicine; formerly Assistant Professor of Pathology, Harvard Medical College, etc. and Edwin S. Gault, M.D., F.C.A.P., Associate Professor of Pathology and Bacteriology, Temple University, School of Medicine. The Blakiston Company, Philadelphia, Pa., and Toronto, Canada. 764 pages. 740 illustrations, a number in colors. 261 case histories. $12.00.

It has been the experience in practically all institutions for the mentally ill in this country, where mass radiography has been carried out, that these hospitals are virtually repositories of tuberculosis. A. H. Russakoff, M.D., Am. Rev. Tuberc., Jan., 1947.

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RESEARCHERS DESCRIBE ARTIFICIAL KIDNEY

An artificial kidney developed by three researchers of Toronto, Canada, is saving the lives of persons whose kidneys do not function or function improperly.

The three reseachers — Gordon Murray, M.D., Edmund DeLorme, M.D., and Newell Thomas — describe the apparatus in the August 28 issue of The Journal of the American Medical Association.

When secretion of urine stops following blood transfusions, certain conditions in pregnancy or poisoning, they say, toxic substances accumulate in the blood. Physicians formerly have had little control over this condition, the researchers point out, and when it persists it is always fatal.

"It was with great satisfaction, therefore," the article continues, "that we were able to produce a machine which will reproduce the function of the kidney and will remove many, if not all, of the toxic substances that cause the fatal result."

The apparatus has been successfully used on patients and several days of treatment cause no ill effects, the reseachers report.

The artificial kidney is the product of many years of work by these men, who began with attempts to transplant kidneys and to filter blood in animals. In its present form, they say, it operates by means of a cellulose membrane which filters the blood, separating large particles from small ones.

This membrane is placed in a chemical bath containing sodium chloride, other chlorides, sodium phosphate, sodium carbonate, and dextrose, the article explains. A pump removes blood from the large trunk vein of the body which provides circulation to the legs and passes it into a tube, through the membrane, and into the opposite vein of the flank.

As the blood of a patient circulates through this route, the toxic substances fall out through small openings of the membrane. Large molecules such as proteins and hormones are carried back into the blood stream.

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The substances which are filtered out plus sugar and water escape rapidly into the surrounding bath where buffering takes place — a chemical process which prevents alterations in the solution which would be harmful to the patient. By changing the solution frequently, the rate of filtration can be kept at a comparatively high speed, the researchers say.

Provided that the blood, both in the patient and as it enters the machine, is adequately treated with heparin, a drug which prevents clotting, the machine gives "no difficulty whatever," they observe.

Laboratory results point to further possible uses of the artificial kidney, the researchers indicate.

"Experimentally," they say, "we have demonstrated that when an animal is having a deficiency of oxygen a fairly large quantity of oxygen can be supplied by this machine. Moreover, the blood stream of the animal could be supplied with almost any desired quantity of sugar. There was evidence to suggest that various types of medication and treatment might be given for shock or severe burns."

OUR GREATEST CHALLENGE

A whole new group of special weapons — atomic bombs, biological products, and chemical agents that science has made available — is projecting an unprecedented challenge to the medical profession and those associated with rendering service to the Nation in the event of another war.

The necessity of the medical profession's being ready and prepared for whatever national emergency arises is obvious. In the event of war the medical, health, and sanitary problems will be greater than ever before, because not only will they involve the armed forces but whole civilian population as well.

Happier contemplation of the fact that man has apparently found the basic source of power should lead the world to hope that the newly acquired knowledge might be applied to the problems of disease control and similar difficulties for a new era in human existence.—Edward L. Bortz, M. D., in *Pennsylvania Medical Journal.*

Sodium floride treatment to check tooth decay is being demonstrated nationally by mobile units of the USPHS. Congress has earmarked $1,000,000 for the program. —*R.N.*



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FIND HISTAMINE VALUABLE IN TREATING MIGRAINE HEADACHE

Histamine, a body tissue chemical thought to cause many allergic reactions, is valuable in preventing and treating migraine headache, report two physicians of the Mayo Clinic at Rochester, Minn.

Writing in the July 24 issue of The Journal of the American Medical Association, the physicians — Dorothy Macy, Jr., and Bayard T. Horton — describe a study of the use of histamine in treating migraine headache at the Mayo Clinic from 1937 to 1946.

Histamine, which has no narcotic effect, was given by injecting beneath the skin and by dripping into the veins. "The greatest improvements occurred among the patients receiving histamine by both routes," the article points out.

The physicians divided the 144 patients studied into typical and nontypical cases. Both kinds showed periodic headaches, but in addition the typical cases had at least two of the following symptoms while the nontypical cases had only one: (1) Upset stomach, (2) brain disturbance, and (3) a family history of migraine.

Headaches caused only by psychic factors and nervous tension were not considered migraine, although nervous tension is frequently one of the symptoms of the disease.

True migraine, as regarded in the study, is a condition of constriction of the blood vessels followed by dilation which often produces swelling.

Of the 144 patients 98 showed 25 to 100 per cent improvement. However, the treatment is not a cure, the physicians emphasize.

"The duration of freedom from migrainous attacks parallels rather exactly the duration of administration of adequate maintenance doses of histamine. Patients free of symptoms after one year or more were still taking histamine once daily or every other day."

Sir Harry Lauder confesses that the smartest answer to a stupid question he ever heard was delivered to him in Butte, Montana, by an aged Negro cab driver.

On his visit to the city, Lauder made the trip from the railroad station to the town and return in this aged Jehu's dilapidated buggy. The town was about a mile from the station and on the return trip the famous Scot inquired irritably why they had built the station so far away.

"I don' jes know," replied the old Negro, "unless it am to have de depot near de railroad."

SCHERING APPOINTS NEW FIELD REPRESENTATIVE

Schering Corporation of Bloomfield and Union, New Jersey, announces the appointment of a new representative to the Schering professional service staff.

Mr. Michael C. Purpura of Chicago is a pharmacist and also attended the Navy Medical Technician School. During the War, he served as a Chief Pharmacist's Mate in the United States Navy. Mr. Purpura will have his headquarters in Chicago.

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Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

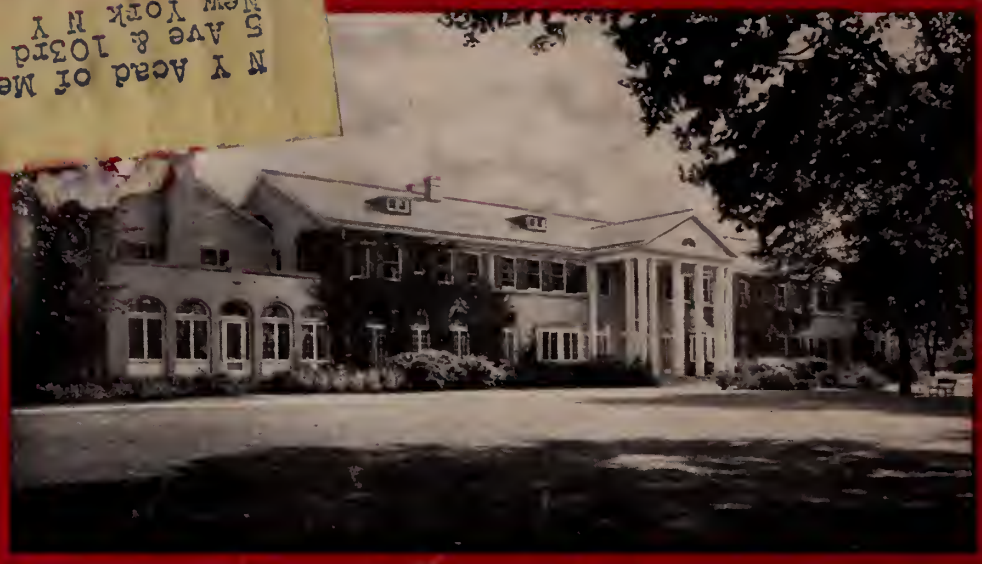
*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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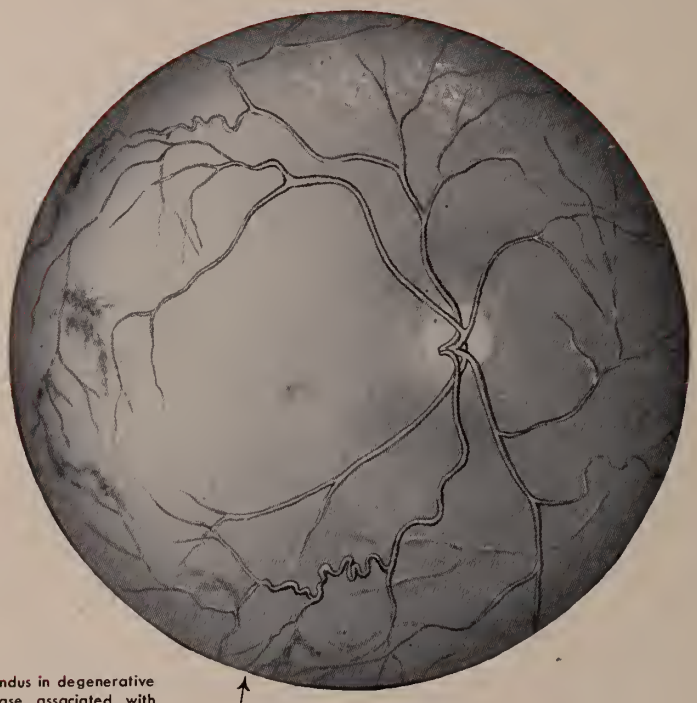
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... and Other Original Articles

(See page 5 for complete Table of Contents)

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TABLE OF CONTENTS

NOVEMBER, 1948
Vol. 94, No. 5

ORIGINAL ARTICLES

Intrathecal Therapy Contraindicated for Meningitis, *Archibald L. Hoyne, M.D.*, Chicago 295
The Differential Diagnosis of Poliomyelitis, *Henry W. Woltman, M.D.*, Rochester, Minnesota 299
New Method of Cholecystenterostomy, *Carl Werelius, M.D.*, Chicago 306
Deep Mycotic Infections in Illinois, *Esther Meyer, Ph.D.*, Chicago and *Marvin S. Kagen, M.D.*, Appleton, Wisconsin 308
Unnecessary Rectal Operations Done in the Presence of Cancer of the Large Bowel, *Raymond W. McNealy, M.D.*, and *Durand Smith, M.D.*, Chicago 315
The Direct and Indirect Therapy of Acute Respir-.... atory Infections, *Ben E. Goodrich, M.D.*, Detroit 317
Precocious Puberty in a Three Year Old Girl, (Case Report), *Luis Pavon Sarrelangue, M.D.*, Nogales, Sonora, Mexico 322

EDITORIALS

Hoyt Named Illinois' Top G. P. for 1948 277
1947-1948 Journal Awards are Presented 278
"The Nation's Health; a Ten Year Program" .. 280
Physicians for the Army 281
First Medical Students Receive Joint ISMS—IAA Loans for Training 282
The Physician in Diabetics Detection 283
Book Reviews 56

MEDICAL ECONOMICS

The Mighty Gene 285

CORRESPONDENCE

Your Mental Hospitals 288
Crippled Children's Division Lists Clinics 289
New Health Series on Radio 290
Vacancies Under Civilian Resident Program 290
Warns of Danger in Distributed Solution 290
Dermatologists to Meet in Chicago, Dec. 4-9 291
Medical Care Fee Schedule 291
Symposium on Medicolegal Problems 292

STATE DEPARTMENT OF PUBLIC HEALTH

Program for Prevention of Dental Caries 293

PHYSICAL MEDICINE ABSTRACTS 44

NEWS OF THE STATE 325

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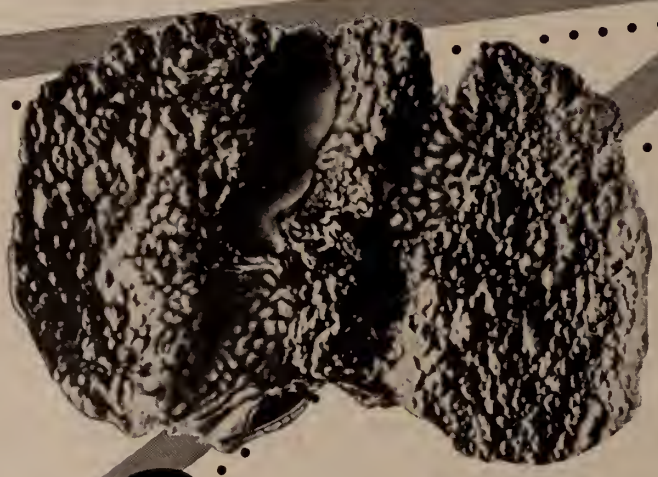
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*Lockhart, E. E.: Harris, R. S.; Tapia, E. W.; Lockhart, H. S.; Nutter, M. K.; Tiffany, V., and Nagel, A. H.: J. Diet. Assn. 20:742 (Dec.) 1944.

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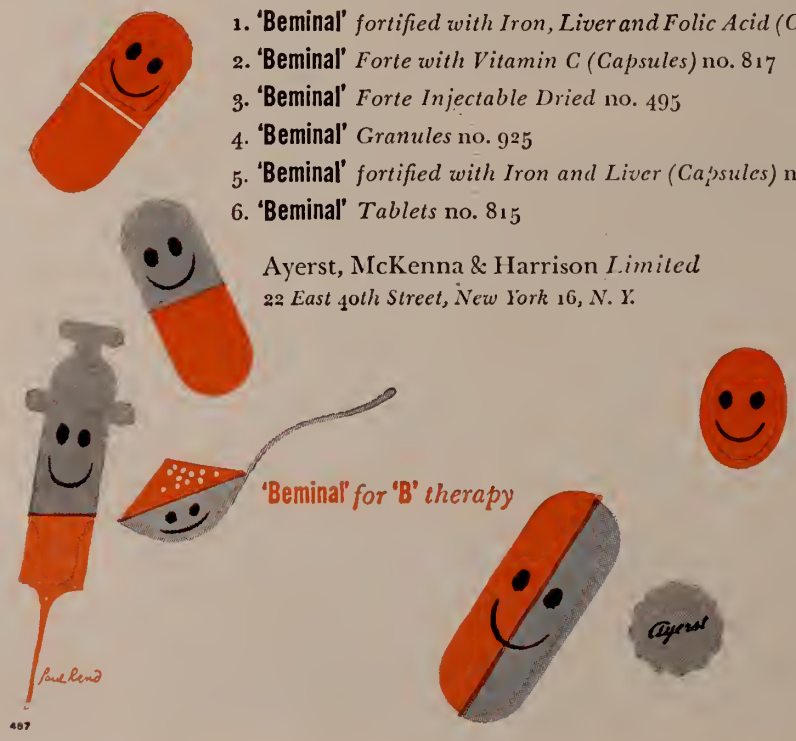
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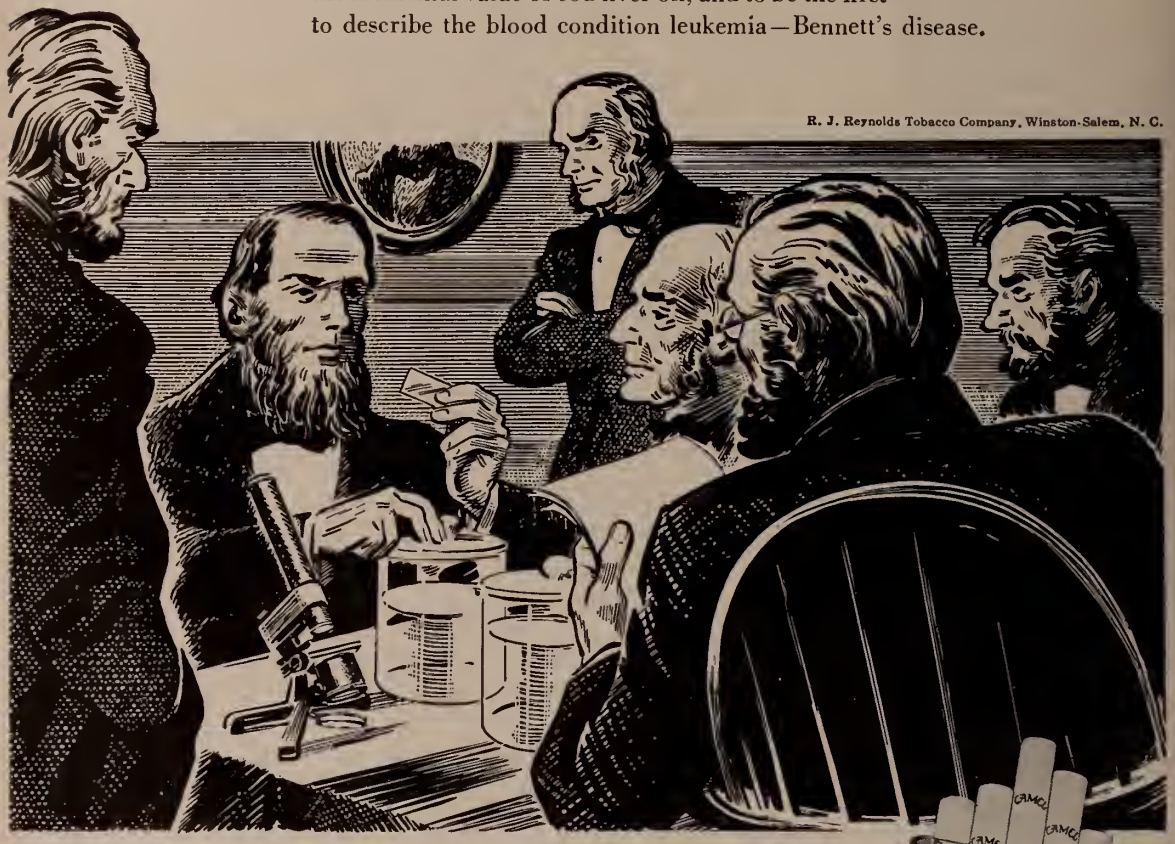
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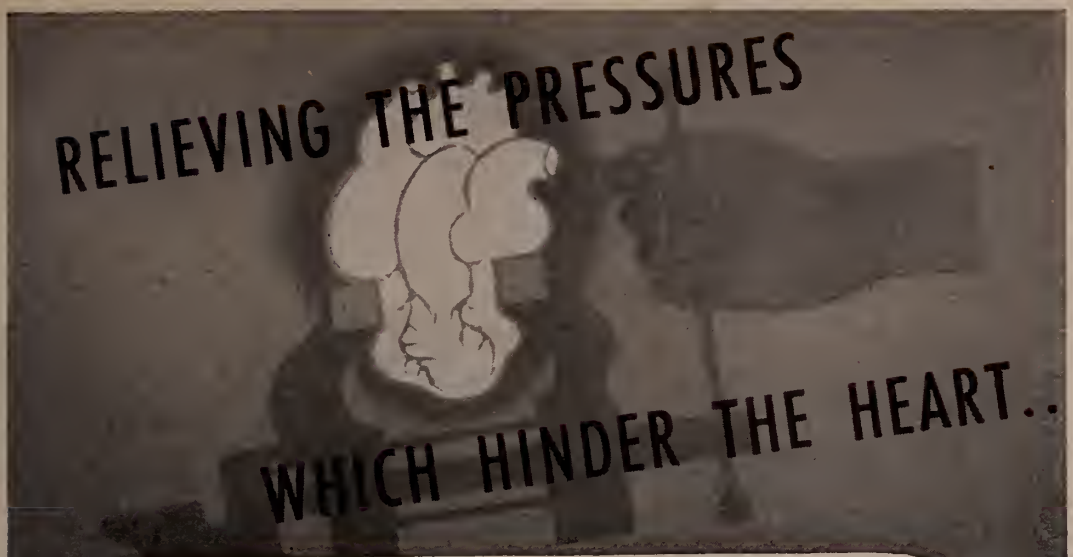
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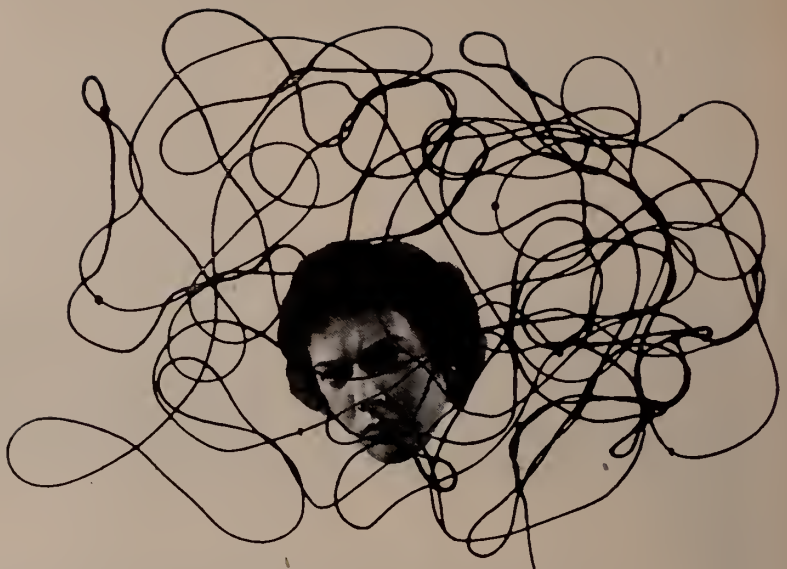
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The editorial management is under the direction of Dr. John B. Youmans, Dean, College of Medicine, University of Illinois. The principal contributors and their subjects are the following well-known medical educators and writers:

Internal Medicine—Dr. Hugh J. Morgan, *Professor of Medicine, Vanderbilt University, Nashville, Tennessee.*

Obstetrics—Dr. Frank Whiteacre, *Professor of Obstetrics and Gynecology, Memphis, Tennessee.*

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These men will have associated with them an equally competent and distinguished group of authors in special fields. Associate contributors include:

Allergy—Dr. Harry L. Alexander, *Washington University.*

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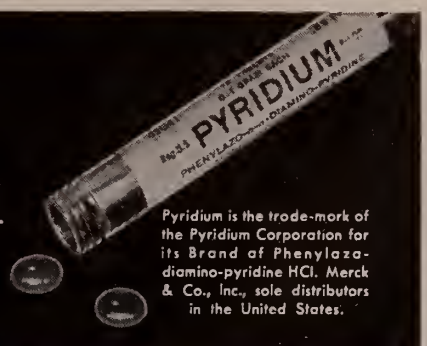
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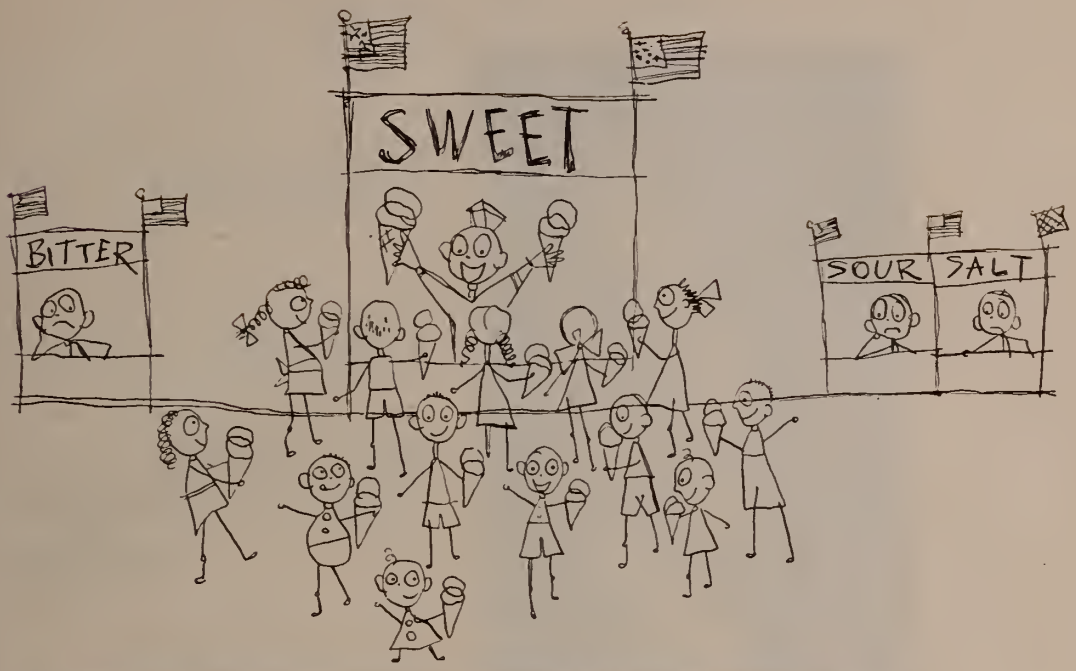
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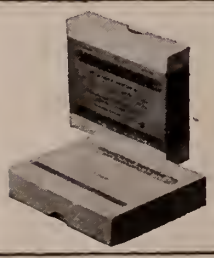
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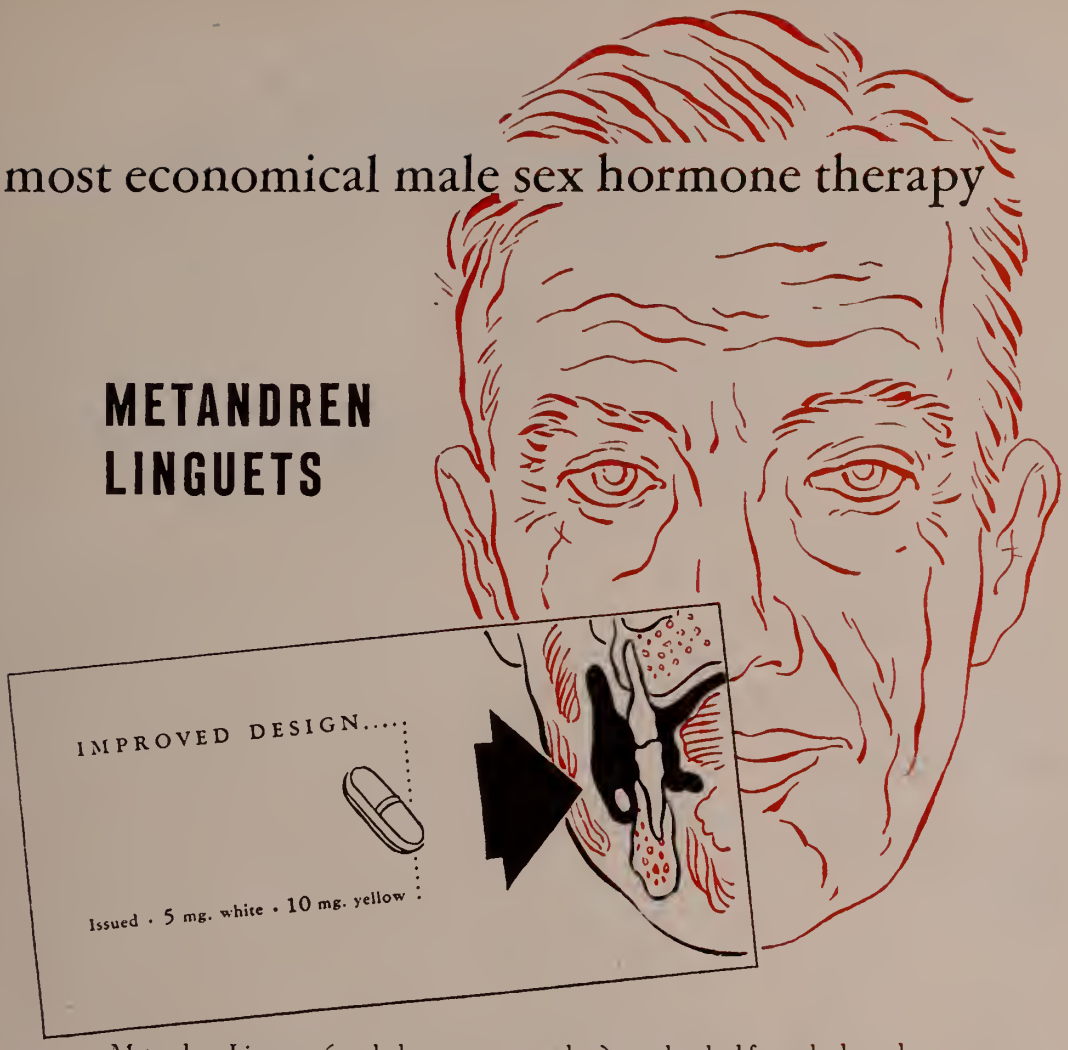


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*J. E. Jorpes, Heparin in the Treatment of Thrombosis, Oxford University Press, London, 1946. **P .G. C. Martin, *Brit. M. J.* 2:308, 1944.

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Lilly in South Africa

LIKE many youthful countries, the Union of South Africa has in the past been dependent upon other nations for its physicians and medical teachers. Today, however, South Africa is producing its own scientific men and its universities are rapidly becoming centers of medical research. The heterogeneous population and the great variety of interesting biological and medical problems present an inviting field to the medical researcher.

Johannesburg was selected in 1938 as the headquarters of the first resident medical service representative of Eli Lilly and Company. Research institutions and the medical and pharmaceutical professions have since been regularly visited. Here, as elsewhere, the Lilly Research Laboratories offer the assistance of their staff on mutually interesting problems. It is hoped that physicians everywhere may by this means share in the practical benefits of South African medical research.



The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 5 November, 1948

HOYT NAMED ILLINOIS' TOP G. P. FOR 1948

The Illinois State Medical Society has chosen Lee Turner Hoyt, M.D., of Roseville, Warren County, as the outstanding general practitioner of Illinois for 1948.

The announcement was made by Dr. Percy E. Hopkins of Chicago, president of the state society, at a dinner concluding a day-long postgraduate session staged by the society for the benefit of doctors in Warren and surrounding counties.

Dr. Hoyt, in addition to the honor thus bestowed on him by the 10,000 members of his profession in Illinois, will become Illinois' candidate for the gold medal to be awarded to the national outstanding general practitioner by the American Medical Association at the interim meeting of its house of delegates in St. Louis beginning November 30. Each of the 48 states will present a competing candidate for the honor and the final selection will be made by the house of delegates of the A.M.A.

Dr. Hoyt was chosen by a secret committee of the state society, which decided among candidates submitted by the ninety-two county medical societies making up the state organization. County candidates were chosen by county committees from among names put forward by local agencies, either lay or professional.

Dr. Hoyt, it was explained by Dr. Hopkins in making the announcement, is the only physician in Roseville, a town of about 1,000 population about twelve miles south of Monmouth.

The territory he serves includes a rural area lying in Henderson and Knox Counties, with a population of about 4,000. From his office in Roseville he covers his territory by driving more than 100 miles a day and often his daily tally of patients attended will run as high as 75 or 80, most of them in his office. He has hospital privileges in Monmouth, Macomb, Galesburg and Burlington, Iowa. He has practiced medicine for 26 years, seven years in Raritan, Henderson County, and 19 in Roseville.

Medically, Dr. Hoyt rates high among his colleagues for the quality of his work, both medical and surgical. His aid as consultant is frequently sought in diagnostic problems. He has no assistant, but maintains a staff of two registered nurses, and has his own laboratory. Before the coming of the hard roads to downstate Illinois, he kept two teams of horses constantly employed, but now depends on two automobiles. Similarly, through assiduous attention to medical and general scientific journals, attendance at refresher courses and lectures such as the postgraduate meeting here today, Dr. Hopkins said, Dr. Hoyt keeps up to date on medical knowledge and none of his rural patients,

no matter how rough the gravel road to his farm, gets anything but the best modern medical care.

Professionally, Dr. Hoyt is a member of his county and state medical societies and a fellow of the A.M.A., a member of the Mississippi Valley Medical Association and a member and former president of the Monmouth Medical Club and Monmouth Hospital Staff. He has served as Warren County's delegate to the state society. His most recent publication was an article in the *Illinois Medical Journal* on the dangers of sulfa drugs when given promiscuously.

Dr. Hoyt was born November 25, 1895, in Good Hope, Ill., the son of Oris T. Hoyt, a farmer, and Isabelle White Hoyt. His brother, Guy M. Hoyt, is assistant superintendent of the Los Angeles, Calif. district high school system. April 2, 1920, Dr. Hoyt was married to Miss Bessie H. Jones of Bushnell, Ill. They have two sons, John Lee, born in 1924, a veteran of the Army Air Corps, and Robert Louis, born in 1925, a Navy veteran, both now taking medical courses in Chicago.

Dr. Hoyt attended elementary school in Walnut Grove Township, McDonough County, and the academy of Western Illinois Teachers' College. He took his premedical course at the University of Chicago, and his M.D. degree at Rush Medical School in 1921. He interned at West Suburban Hospital, Oak Park, Illinois, in 1921 and 1922.

As a member of his community, Dr. Hopkins continued, Dr. Hoyt has found time to serve on the local board of education and to give earnest support to the local high school's athletic program. He has also been the prime mover in establishing a modern health program in Roseville, with emphasis on preventive medicine and immunization. He was president of the county chapter of the National Foundation for Infantile Paralysis and is chairman of the county tuberculosis district board, operating a model tuberculosis control program.

Personally, Dr. Hoyt is of middle height, alert and quiet, modest and friendly, giving a positive impression of confidence and sympathy. He is a good listener and shrewd questioner. He is a member of the Christian church and a Republican. A fisherman and a hunter, he maintains a membership in the Illinois River duck club. However, his principal hobby is floriculture, especially roses, and his rose garden, which emphasizes climbing plants, is one of the sights of Roseville. He has experimented for years in scientific soil improvement, not only for his flowers, but in the broader field of general agriculture.

During World War I, Dr. Hoyt, then still in medical school, enlisted in the Army EMRC, but saw no active service. He offered himself in World War II, was rejected for the Army, but joined the Illinois Reserve Militia and holds a major's rank in the 6th Infantry Regiment.

Perhaps the most unusual tribute ever accorded a physician by his home town folks is the sign just below the windows of Dr. Hoyt's office overlooking the intersection of State Highways 67 and 124, which reads:

"Reserved for physician by order of the village board. Fine $5."

His fellow townsmen and patients know how hard he works and how precious his time is if he is to care for all the misery that is brought daily to his kindly hands. At least they can save him the task of hunting a place to park. There is one parking ticket that can never be "fixed."

1947-1948 JOURNAL AWARDS ARE PRESENTED

Dr. Kenneth L. Roper and Dr. Bert I. Beverly were adjudged the prize winners in the second annual scientific and literary competition for the best articles published in the Illinois Medical Journal during the 1947-1948 fiscal year.

The Editorial Board and the Journal Committee held a joint meeting in Chicago to select the winners in the two classes: $100 for the best paper from a literary standpoint, and $200 for the most outstanding piece of original work presented in a paper or scientific editorial.

The award of $100 was made posthumously to Dr. Bert I. Beverly of Oak Park for the best paper from a literary standpoint, for his article, "Mental Aspects of Growth and Health" which was published in the December, 1947 issue of the Illinois Medical Journal.

The $200 award for the most outstanding piece of original work as presented in a paper was given to Dr. Kenneth L. Roper of Chicago for his article, "Lancaster's Technique of Cataract Extraction" which appeared in the February, 1948 issue of the Journal.

Other papers which received serious consider-



Lee Turner Hoyt, M.D.

ation by the Editorial Board and the Journal Committee for the above awards were: "Surgical Treatment for Carcinoma of the Esophagus" by Philip Thorek; "Microbiological Assay of the Antibiotics" by E. E. Vicher and S. A. Levinson; "Pulmonary Complications Due to Endobronchial Foreign Bodies" by Paul Holinger, and "Diagnosis of Accessible Cancer" by Danely P. Slaughter.

Awards last year were made to Dr. John R. Porter of Rockford for his paper, "The Positive Serological Reaction Is Not A Diagnosis of Syphilis" as the best written article from the literary standpoint. In the scientific field, a tie resulted, and duplicate awards were given to Dr. Henry C. Sweany for his paper, "New Application of Laboratory Methods in Diagnosis of Tuberculosis" and to Dr. Warren H. Cole, for his manuscript on "Carcinoma of the Colon".

The judging of the articles was made on a "point system" which considered: (1) What does the article contribute scientifically? (2) How easy is it to read? (3) The construction and grammar, and (4) With what authority does the author speak? (bibliography, research, etc.).

The awards are open only to members of the Illinois State Medical Society, and the Editorial Board and Journal Committee judged the articles which appeared in the July 1947 through June 1948 issues of the Illinois Medical Journal.

May we call your attention to the fact that it might have been possible for one article to win both prizes. Several of the articles listed above, were considered in both classes. The Editorial Board and the Journal Committee went on record officially that "anyone winning the award for the most outstanding scientific contribution, will automatically be eliminated from the list to be considered for the literary award".

We hope that all future contributions to the Illinois Medical Journal will be written carefully, and that articles of scientific value, written graphically and grammatically, will be submitted for publication during the coming year.

Only seven states — Colorado, Connecticut, Massachusetts, Michigan, North Dakota, Rhode Island and Wisconsin — have two and a half or more beds available for the tuberculous per annual death from tuberculosis. Mary Dempsey, NTA.

"THE NATION'S HEALTH; A TEN YEAR PROGRAM"

The long expected report of the Federal Security Administrator to the President of the United States, on the National Health Conference held in Washington last May was released recently. The book of 186 pages is most interesting. Mr. Oscar R. Ewing states frankly in the foreword that "there was no agreement on the question of national health insurance and my recommendations of such a program must be clearly understood as in no way expressing the views of the Assembly. It took no position, one way or the other, on this question".

Ewing states that "every year over 300,000 people die whom we have the knowledge and skill to save. This stark fact proves that the present system is inadequate. "In another portion of the report the number is raisd to 325,000, these being listed as follows:

Communicable diseases, 120,000
Cancer and Heart Disease, 115,000
Accidents, 40,000
Infant and maternal, 30,000
Other, 20,000

As would be expected in such a report, reference is made to the five million men declared physically or mentally unfit for the armed forces. This, as we all know, has been a favorite topic of discussion in recent years by all proponents of compulsory health insurance. These figures when broken down, do not, as many people still believe, show that inadequate medical care is responsible for the major portion of this group.

The list of deaths annually "that we have the knowledge and skill to prevent" appears repeatedly in the report, and quite obviously many people reading the report would be led to believe that under a compulsory health insurance plan these lives could be saved. There is no reference in the report to show improved statistics under the present compulsory health insurance plans in operation in other countries.

Chapter I, entitled "The Health of the Nation", starts out with this interesting statement: "During the last generation, the United States steadily improved its health record, but the nation and the people will suffer losses through sickness, disability, and death, much of which is unnecessary".

The report fails to show the percentage of the

325,000 deaths which we have the knowledge and skill to save died without medical attention, or that inadequate care was given. No comparison is made anywhere in the book of our statistical records as compared with those of other countries. According to the report we need many more physicians, dentists, nurses, and definitely more medical schools. The need for 900,000 additional beds in general hospitals is stated. These, according to the report, should cost approximately $10,000 per bed.

In hospital construction at the present time it has been shown that the actual cost is approximately $15,000 per bed, so instead of the nine million dollar estimate on the cost of hospital construction, or enlargement, it would be nearly 14 billion dollars under present construction rates.

The report is long but interesting, and shows definitely what is in the minds of those responsible for its appearance at this time. In the preparation of the report the administrator expresses his thanks to the members of the Executive Committee and gives the list of its members. Included in this list are the names of the President, President-Elect and Secretary-General Manager of the American Medical Association. These men gave freely of their time and knowledge in their respective presentations, and it is quite obvious that the views expressed as to the solution of the apparent present day problems in health and medical care, were not developed as a result of their statements.

This report can be secured by writing to the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., and the cost is one dollar. We would recommend that physicians everywhere secure a copy of this report and familiarize themselves with its contents. It will most likely be used freely during coming sessions of the Federal Congress, especially by those who insist that we must have a compulsory health insurance plan in operation in the United States.

Mass radiography of all institutions for the mentally ill should be repeated every two years. It is noteworthy that reinvestigation has been productive of a significant number of cases who were negative on previous examinations. A. H. Russakoff, M. D., Am. Rev. Tuberc., Jan., 1947.

PHYSICIANS FOR THE ARMY

In the September 25 issue of the Journal of the American Medical Association, a letter was published, written by Major General R. W. Bliss, the Surgeon General, relative to the needs of the Army. He stated that at least 4,000 additional medical officers will be needed by June, 1949. The need is not merely one of numbers, according to the Surgeon General, but that of specialties.

Under existing laws none of the 4,000 physicians needed is obligated to enlist even though the need is urgent. General Bliss pointed out that while the Army, including the Air Force, must secure 4,000 doctors by next June, it cannot depend entirely upon the group of young men who were permitted to complete their medical studies during the recent war, and as yet have not rendered any service to the government. Most of these men received liberal government stipends.

Bliss stated that the corps has grown, but fast enough to keep pace with the increasing requirements precipitated by the more than five-fold expansion in the combined strength of the Army and the Air Force. The situation did not become critical until recently because the Army was permitted to retain on active service, or call to active service for a tour of duty of about two years, recent graduates of medical schools who had been deferred from wartime service. This deferment permitted them to complete their education which was in most cases, paid for in whole or in part by the government.

The wartime legislation which obligated this group of A.S.T.P. students for two years of Army service, was terminated by law in June, 1946, and was limited to graduates before that date.

This problem was presented before the Council of the Illinois State Medical Society at a recent meeting, and a resolution was prepared, introduced and unanimously approved. It was released to the press at that time, and the text of the resolution is as follows:

"Whereas the reestablishment of a large Army, Navy and Air Force imposed on the United States by the international political situation, demands the services of approximately 6,000 additional medical officers by June, 1949, and

"Whereas, the medical profession of the

United States accepts, as it has always done, the responsibility for providing the qualified physicians necessary to give the best possible care to the officers and enlisted personnel of the nation's Armed Forces, and

"Whereas, Illinois, as a state better supplied with physicians than many other states of the Union, must contribute approximately 600 of such additional medical officers, and,

"Whereas, there are in Illinois a number of physicians of the specified age and training who for various reasons were not called for service during World War II, and

"Whereas, there is also, in Illinois a large number of young, recently graduated physicians whose medical education was paid by the National Government under the A.S.T.P. and V-12 programs, but who were not called for service,

"Now, therefore be it resolved that the Council of the Illinois State Medical Society, after due deliberation, finds that, while such individuals have no legal obligations to volunteer for commissions as medical officers, they are under a moral obligation to do so;

"That the Council of the Illinois State Medical Society earnestly requests all such individuals to present themselves at the earliest possible moment to the proper officers of the Army, Navy or Air Force as candidates for commissions as medical officers in the Armed Forces, thus repaying the debt they owe to the nation as citizens and as beneficiaries of the programs by which their medical educations were conferred upon them;

"That the Council of the Illinois State Medical Society, with equal emphasis, urges all physicians who, as hospital or school administrators, as directors of clinics, or of laboratories, or in similar capacities, have any individuals on their staffs or faculties, or as assistants or residents, to make them immediately available for medical service, and to bring any possible pressure on them to volunteer for such services."

During World War II, approximately 4,000 Illinois physicians voluntarily entered the medical corps of the armed forces, many of these men well beyond draft age, and entering as badly needed specialists. Many others who had seen one or more war services in the past and who were beyond the age limits for acceptance, endeavored in every way possible to be accepted for services in hospitals, or in this country during the war.

General Bliss stated that more than 2,000 doctors now serving on temporary duty in the Army will be returned to civilian life during the coming year, which increases the problem at hand. Even though there is no legal liability, as has been shown in the letter of General Bliss, there definitely is a moral responsibility on the part of the younger men in medicine who received their training at government expense and were deferred from service in the latter part of the recent war as medical students. Likewise there is a moral obligation as citizens of the greatest of all nations, and one of the few remaining true democracies in the world today.

It is hoped that the appeal of General Bliss, the Surgeon General of the United States Army, will not go unheeded, and the response will be gratifying to him and to those responsible for the care of the Armed Forces in time of peace, as well as in time of war.

FIRST MEDICAL STUDENTS RECEIVE JOINT ISMS-IAA LOANS FOR TRAINING

The first three $1,000 checks to finance medical education for students who promise to practice medicine in rural Illinois were presented to the beneficiaries at a dinner in Chicago September 24.

The money came from a $100,000 fund established recently by the Illinois State Medical Society and the Illinois Agricultural Association after studies had shown the serious need of new physicians in various rural areas of the state. With each society contributing $50,000, it is known as the Student Loan Fund and is administered by a board composed of three representatives from each organization.

The three students who received the checks are:

Burton E. Bagby of Mounds, Pulaski County, 35 years old, a veteran of four years' service and father of three children, who took his premedical course at Memphis (Tenn.) State College and will study at Loyola University Stritch College of Medicine.

L. C. Fiene of Sparta, Franklin County, Illinois, 21 years old, who took his pre-medical work at Southern Illinois University, Carbondale, and will attend the University of Illinois College of Medicine.

Lawrence R. Irish of Hancock County, 20 years old who studied at the University of Illinois and will also attend its College of Medicine.

The students met for the first time at the office of Ivan A. Parett, executive of the I.A.A., who serves as secretary of the Student Loan Fund Board, where they were greeted by the members of the board: Dr. Edwin S. Hamilton of Kankakee, Dr. Everett P. Coleman of Canton and Dr. Harlan English of Danville, for the I.S.M.S., and Floyd E. Morris of Buffalo, K.T. Smith of Greenfield and Lyman Bunting of Ellery for the I.A.A. Also present were Dr. Percy E. Hopkins of Chicago, president, and Dr. Harry M. Hedge, chairman of the council, of the state society. After the legal details had been concluded, the group adjourned to a nearby restaurant for dinner.

To be eligible for loans, students must be approved by the Farm Bureau and Medical Society of their home counties, must have concluded their pre-medical work and must meet the qualifications of a Class A medical school. In accepting the loans, they agree to return to a rural area of Illinois to practice at least until the loan is repaid.

Applications are already being received for the next school year. They should be addressed to Mr. Parett at 43 East Ohio Street, Chicago.

THE PHYSICIAN IN DIABETICS DETECTION*

The discovery and treatment of diabetes mellitus at an early stage demands the attention of all practicing physicians. Failure to discover and treat diabetes early results in preventable disabilities and impairments of health. In the Diabetes Exhibit at the Annual Meeting of the American Medical Association held in Chicago in June, 1948, it was shown that the mortality rate for diabetics first seen when a complication had occurred was three times the rate for diabetics first seen earlier and before impairments had developed. Actually the future for the diabetic patient under modern medical treatment is brighter and more hopeful today than ever before.

In 1929, Dr. George H. Bigelow and Dr. Herbert Lombard began a study of chronic disease in Massachusetts which led to the publication of statistics showing that the number of diabetic patients in Massachusetts was far higher than had been heretofore thought. In 1935, a National Health Survey was conducted which confirmed these figures. In Oxford, Massachusetts results of a survey by the United States Public Health Service indicates that at least a million undiagnosed diabetics exist in the United States and Canada.

District and state medical societies now have the opportunity to take the lead in the fight against diabetes in response to an appeal to the practicing physicians of the United States, presently being made by the Committee on Diabetes Detection of the American Diabetes Association. This committee was appointed by Dr. Charles H. Best, President, at the Annual Meeting in June, 1948. Plans are being formulated for National Diabetes Week, December 6 to 12, 1948.

As a first step in a full-scale attack on diabetes, eighth among the leading causes of death, a medical society should appoint its committee on diabetes. The National Committee on Diabetes Detection stands ready to assist local committees in their work. Already the Committee is preparing material containing information on diabetes for use by the physician in his own town. These materials include programs for medical meetings, radio broadcasts and spot radio announcements for use by city and county medical societies, and suggestions for cooperation with local hospitals toward the control of diabetes.

The Committees on Post-Graduate Instruction in state and county societies should plan instructions and demonstrations in diabetes in county meetings this fall. Also, hospital staff meetings should provide a place on their program for diabetes. Committees on Public Relations and Public Information should plan meetings for instruction of laymen including patients, their families, and all others interested.

Women, too, have an important role to play in the fight to control diabetes. It is significant that diabetes is more frequent among women than among men. It is desirable to enlist the aid of women's organizations, especially the women's auxiliaries of the medical societies, as

*Submitted by Committee on Diabetes Detection, Howard F. Root, Chairman, 81 Boylston Road, Boston, Massachusetts.

an adjunct to the program planned by medical societies.

Already a number of local diabetes associations affiliated with the American Diabetes Association have been formed. More such associations composed of physicians are needed. With the cooperation of the physicians within their area, these associations have accepted the challenge and will strive to find and treat the million hidden diabetics. Associations will be assisted by the American Diabetes Association in attaining such objectives as: More graduate courses in diabetes for physicians; providing better laboratory services; and helping with instructions for patients. Now is the time for action—will the practicing physicians seize this opportunity for progress in an all-important field or will he prefer to surrender to others his responsibility for diabetes detection and treatment?

BEG YOUR PARDON

We regret that in changing articles from our old to our new type style, the name of G. O. Wellmann, M. D., author of "Thrombophlebitis and Phlebothrombosis" which was on page 180 of the September issue, was incorrectly spelled. The author's name will appear correctly in our Volume Index.

PROVE AUREOMYCIN VALUABLE AGAINST FOUR DISEASES

Aureomycin, the new golden-colored antibiotic drug, is being used to treat patients with Rocky Mountain spotted fever of the eastern type, undulant fever, typhoid fever, and certain infections of the urinary tract, report five researchers from the Department of Preventive Medicine, Johns Hopkins University School of Medicine, Baltimore.

Writing in the September 11 issue of The Journal of the American Medical Association, the researchers — Morton S. Bryer, M.D.; Emanuel B. Schoenbach, M.D.; Caroline A. Chandler, M.D.; Eleanor A. Bliss; and Perrin H. Long, M.D. — report on clinical tests in the treatment of these diseases with aureomycin and on tests with animals to determine the effectiveness of the drug against other diseases.

Aureomycin is one of the newer drugs produced from molds. It is manufactured from the chemicals made by a thread-shaped mold that belongs to the group that produces streptomycin.

Five patients with Rocky Mountain spotted fever of the eastern type who were treated on the third to the fifth day of illness had no fever and showed no symptoms of the disease within 13 to 72 hours.

A patient with chronic undulant fever had no fever three days after aureomycin therapy was begun. Laboratory cultures of the patient's blood, which had been repeatly positive for the disease, became sterile 48 hours after treatment with aureomycin was begun. This patient has shown no fever and no symptoms for more than two months, and blood cultures have remained sterile for the same length of time.

Two typhoid fever patients treated with aureomycin showed "favorable initial responses."

Infections of the urinary tract in two patients "were sterilized, and evidence of inflammation disappeared when patients were treated with aureomycin by mouth," the article says.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Emmet B. Bay, Edwin F. Baker, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Ford K. Hick, Edwin F. Hirsch, May McDonald Milligan, Marie Wessels, Walter M. Whitaker, Holland Williamson.



The Mighty Gene

The enormous role played by heredity in man's health, diseases and death becomes evident as the science of human genetics develops. The physical and mental make-up of every person results from the interplay of three factors, the germ plasm from the mother and from the father, modified by the environment.

Life, at its beginning, results from the union of two cells, ovum and sperm. In those two tiny cells lies much of the destiny of the potential individual. The sex is there, the hair and eye color, the bodily build, the hereditary physical and mental characteristics and defects and perhaps the cause of death. Environment may influence the size to some extent, and may modify the disposition but no amount of sunshine or fertilizer can grow a lily from a dandelion seed. The sperm and ovum unite to form one cell, the fertilized egg. The parent cells are essentially equal in their hereditary influence for each contains twenty-four chromosomes. Each chromosome is a tightly coiled filament on which are hundreds and thousands of genes. The male set of chromosomes exactly matches the female set, save for the sex chromosomes. In other words there are twenty-three pairs of similar chromosomes or autosomes and one pair of dissimilar chromosomes, allosomes, the sex determiners. When the male and female cells join each chromosome seeks its mate and they unite gene for gene (meiosis). Each gene therefore is a compromise of male and female elements. The new fertilized cell contains twenty-four chromosomes, each of which is a union of two. These newly formed chromosomes divide immediately to form forty-eight, each of which is one-half from the mother and one-half from the father. Subsequently the genes divide to create other genes like themselves and identical with those of the original germ cell. As the genes divide so do the chromosomes and the cells.

By the process of mitosis the doubled chromosome is divided exactly. In other words every cell in the normally developing individual possesses every chromosome and every gene that was present in the original fertilized ovum. This constitutes our genotype. Each gene, in every chromosome, directs activities in its own sphere. Genes, chromosomes and cells divide and divide causing growth which continues until

death. So dependent are we on heredity that even in old age each cell normally contains the same chromosomes and genes as the original fertilized ovum.

As division continues the multipotential genes form various tissues and organs, muscle, bone, brain, skin, liver and hair. Some genes are dominant over the corresponding gene, some are recessive. On the whole normal genes are dominant over abnormal genes. This tends to prevent deviation from the norm. Some genes act as modifiers, some function for a short time, others remain active throughout life. The potentialities of a gene may be altered by the presence of other genes and by external factors. Within limits each gene directs specific chemical activities; activity which may be started or stopped, accelerated or depressed.

The genotype contains the potentialities for most of our physical characteristics and many of our mental and intellectual traits. With the union of the ovum and sperm the die is cast for much of our future lives. With no fault or no credit to the individual most concerned his life is largely predestined by his genotypes.

External factors act on and modify the genotype to produce the phaenotype. The external factors include the intrauterine environment and the environment after birth. The mother contributes to the child her half of the chromatin substance and the yolk material of the egg and the nutrient materials through her blood plasma. The condition of her uterus before and after the implantation of the fertilized ovum has its effect. Intrauterine environment is modified by the physical and mental health of the mother as well as the chemical and antigenic content of her plasma. The process of birth may greatly alter the product of conception. After birth the infant is modified further through the mother's milk. The part played by the father during the period of gestation may be much greater than is generally supposed for the husband, to a large extent, is responsible for the wife's nutrition, place of abode and mental health. A prospective mother, poorly fed and worried about the necessities of life is more apt to miscarry or produce a dead or premature child. After the child is born both parents assist in the training period, the provision of an adequate diet and the creation of a suitable environment. Later, factors outside the home come into play. Heredity and environment work together to produce the individual and personality.

Rarely genes exhibit variations. Inheritable variations are known as mutations. Mutation usually occurs in a single gene. During the process of fertilization this mutant gene unites with its normal mate; the normal gene usually is dominant; so the mutation is not evident. If however two similarly altered genes fuse the mutation is made manifest. It is highly possible that some unknown lethal homozygous recessives account for some of the abortions in man and animals. Many detrimental mutants die out while others remain to weaken the race. Advantageous mutants may persist and become part of the normal picture.

Mutations are rare, perhaps one variation in a single gene in a million cell divisions. Certain factors increase the rate of mutation. Some of these are ultra violet and roentgen rays, radium, radio active substances, nitrogen mustard and high temperatures. These substances cause mutation in the third and fourth generation. Who would hazard a guess as to the ultimate effect upon the human race of all the radio active substances used in medicine and industry and the increased use of radium and roentgen rays?

Medical genetics is a comparatively new science, yet far more is known than is used by the profession. A carefully developed family tree often aids in diagnosis and prognosis and sometimes in prevention of disease.

The list of inherited diseases is long and includes sickle-cell anemia, congenital hemolytic icterus, pernicious anemis, erythroblastosis, ovalocytosis, diabetes, defects in lipoid metabolism (Gaucher's disease, Nieman-Pick's disease, xanthoma tuberosum), some kinds of blindness and deafness. Certain anatomic abnormalities are inherited such as extra fingers and toes, harelip and cleft palate. Some mental diseases such as dementia praecox, elipsy and infantile amourotic idiocy are included in the list. Telangiectasis, transmitted as a dominant, is lethal when homozygous. Every medical speciality includes a list of hereditary conditions.

Blood agglutinogens and agglutinins are inherited. Much use has been made of this fact in blood transfusion, non-paternity and in forensic medicine. The relation of the Rh factor to

blood transfusion and erythroblastosis is a well established application of genetics to medical problems.

The sex linked diseases form an interesting group. In the determination of sex the Y chromosome, which is small and usually bent, passes from father to son. The X chromosome from the father, which is long and similar to the corresponding chromosome from the mother, passes to the daughter. Sex chromosomes from the mother are indescriminate and may be passed to either daughter or son. The X chromosome from the mother and from the father are similar and unite gene for gene in the formation of the female offspring. For this reason recessive sex-linked characters are not manifest in the female unless they are homozygous. In the male it is very different. When the short Y chromosome from the father unites with the longer X chromosome from the mother it forms a doubled chromosome with three distinct parts. First, a portion of each chromosome unites gene for gene forming the homologous region. Second, there is a portion of the X chromosome which is not opposed by any other chromosome, known as the non-homologous portion of the X chromosome. Third, there is a small unopposed portion of the Y chromosome, known as the non-homologous portion of the Y chromosome.

It is obvious, that on the non-homologous portion of the X chromosome, traits can be carried from mother to son unmodified by any paternal gene. On this portion such sex-linked characters as hemophilia and red-green color blindness are carried directly from father to son unmodified of the Y chromosome certain characters are carried directly from father to son unmodified by maternal genes. On this portion are carried webbed toes, hypertrichosis of the ear and ichthyosis hystrix. More than thirty conditions are known to be sex-linked in their transmission.

The physician, knowing the family traits, can look for them and aid in the diagnosis and prognosis of many of the patient's complaints. Best of all a knowledge of hereditary diseases may allow the physician to prevent certain conditions. Members of diabetic families may prevent or postpone the manifestation of the disease by not allowing themselves to become obese and by remaining on a modified low carbohydrate diet. Diabetes is seven times as frequent in the obese. The hereditary diseases dependent upon disturbed lipoid metabolism may be prevented or modified by diet.

Genetic prognosis includes favorable characters as well as diseases. Physical beauty, artistic ability, musical talent and intelligence are transmitted from parents to their offspring.

As the science of medicine becomes broader it embraces not only the diagnosis and treatment of disease but the prevention of disease and the maintenance of health. The eugenists look even further forward to a time when the knowledge of heredity will permit great eugenic programs directed towards the improvement of the human race. — C. L. B.

SOME OTHER ROCK

Recently while riding in the club car of one of the New York Central's best, we picked up a bit of common sense philosophy which we pass on to you. Seated across from us were three men, obviously from deep in the heart of Texas. The train was late and as one of their number wondered whether they would make their St. Louis connection for the last lap of their journey, one of his companions observed "Oh well, what's the difference—as the Georgia cracker said 'if I wasn't sittin' on this rock I'd be sittin' on some other rock.'" Maybe he had something.—Westchester Medical Bulletin.

EMERGENCY CALLS

The doctors of every town and every district society should be so organized that emergency calls, real or imaginary, are handled with reasonable dispatch. The need has been sounded by the American Medical Association and has been emphasized in these pages. Physicians cannot, however, keep themselves constantly on tap like hot and cold running water, as so many of the unthinking public expect of them. Certainly, organization to meet legitimate expectations should and will be put into operation whenever possible.—New England J. Med.

CORRESPONDENCE



YOUR MENTAL HOSPITALS

This is the first of a series of articles to better acquaint the physicians of this State concerning facilities for the care and treatment of patients with mental illnesses.

An average of one new patient was admitted every 40 minutes to one of the State Hospitals for the mentally ill last year; and an average of one new patient was admitted every ten hours, every day and night of last year, to the institutions for the mental defectives. Over 43,000 patients receive treatment each day.

The Illinois Department of Public Welfare has nine mental hospitals located throughout the State; two institutions for the mental defectives; one hospital for the criminal insane; one institute for the study of behavior disorders of children; and one research institution, under the joint management of the Department and the University of Illinois.

Mental Hospitals: 1. Chicago State Hospital; 2. Elgin State Hospital; 3. Kankakee State Hospital; 4. Manteno State Hospital; 5. Peoria State Hospital; 6. East Moline State Hospital; 7. Alton State Hospital; 8. Jacksonville State Hospital; 9. Anna State Hospital.

For Mental Defectives: 1. Dixon State Hospital; 2. Lincoln State School & Colony.

For Criminal Insane: Illinois Security Hospital at Chester, Illinois.

For Child Psychiatry: Institute for Juvenile Research at Chicago.

For Research: Illinois Neuropsychiatric Institute at Chicago.

It is difficult for one to visualize these institutions, unless one has actually visited one of the hospitals. They are almost cities within themselves. The smallest hospital, Alton, has 1,800 patients; the largest, Manteno State Hospital has 7,200 patients. The institutions have their own bakeries, laundries, powerhouses to produce their own heat and electricity; wells and pumping stations for their own water supply; fire departments; and a staff of carpenters, painters and plumbers. In addition to the personnel in the above industries, there are the doctors, nurses, attendants, psychologists, social workers, occupational therapists and recreational therapists, who deal directly with the care and treatment of the patients. Nearly 7,500 persons are engaged daily in the care of the mentally ill.

The days of the "mad house" and the "asylum" "padded cells" are gone, for these are institutions dedicated to the care of those in need of mental treatment, under the latest available procedures and techniques.

In keeping with the modern trends in psychiatry, the Illinois Department of Public Welfare maintains 48 out-patient clinics throughout

the State. Due to the lack of availability of adequately trained professional personnel, many of these clinics are operated on a part-time basis. These clinics examine indigent cases referred by physicians, recognized social agencies, courts, etc. Physicians may refer cases for pre-commitment diagnosis, evaluation or recommendations. Patients on conditional release from the State Hospitals are rechecked at regular intervals. A later report will cover the clinics in detail explaining their activities.

There is no waiting list for admission to the nine mental hospitals, and patients continue to be admitted in spite of the marked overcrowding. Committed patients to the two hospitals for the mental defectives are placed on a waiting list and admitted whenever space is available. By statute there is no charge for treatment in the State institutions in the Welfare Department.

George A. Wiltrakis, M.D.
Deputy Director
Medical and Surgical Service

Note: Later articles will describe other activities of the Department of Public Welfare, method of admission, overcrowding that exists, and the out-patient clinics.

CRIPPLED CHILDREN'S DIVISION LISTS CLINICS

The Division of Services for Crippled Children of the University of Illinois will conduct 29 clinics in 15 Illinois cities during the months of November and December, Dr. Herbert R. Kobes, director announced.

The schedule follows:

Nov. 2 — East St. Louis, St. Mary's Hospital
Nov. 3 — Joliet, Will County TB Sanitarium
Nov. 4 — Hinsdale, Hinsdale Sanitarium
Nov. 5 — Pittsfield, Illini Community Hospital
Nov. 9 — Peoria, St. Francis Hospital
Nov. 9 — DuQuoin, Marshall-Browning Hospital
Nov. 10 — Evergreen Park, Little Company of Mary Hospital
Nov. 12 — Shelbyville, Veteran's Center
Nov. 16 — Watseka, Iroquois County Court House
Nov. 17 — Sterling. Sterling Public Hospital
Nov. 17 — Springfield, St. John's Hospital (Cerebral Palsy Clinic)
Nov. 18 — Rockford, St. Anthony's Hospital
Nov. 19 — Chicago Heights, St. James Hospital (Rheumatic Fever Clinic)
Nov. 23 — Peoria, St. Francis Hospital
Nov. 23 — Casey, High School
Nov. 30 — Effingham, St. Anthony's Hospital (Rheumatic Fever Clinic)
Dec. 1 — Aurora, Copley Hospital
Dec. 2 — Hinsdale, Hinsdale Sanitarium
Dec. 7 — East St. Louis, Christian Welfare Hospital
Dec. 8 — Chicago Heights, St. James Hospital
Dec. 9 — Macomb, St. Francis Hospital
Dec. 14 — Peoria, St. Francis Hospital
Dec. 15 — Rock Island, Augustana College, (Cerebral Palsy Clinic)
Dec. 16 — Rockford, St. Anthony's Hospital
Dec. 16 — Normal, Brokaw Hospital
Dec. 17 — Chicago Heights, St. James Hospital (Rheumatic Fever Clinic)
Dec. 21 — Effingham, St. Anthony's Hospital (Rheumatic Fever Clinic)
Dec. 28 — Peoria, St. Francis Hospital
Dec. 29 — Springfield, St. John's Hospital (Cerebral Palsy Clinic)

The Division of Services for Crippled Children of the University of Illinois is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which lead to crippling. The general clinics are staffed by an orthopedist, pediatrician, and speech and hearing consultant. The former two are engaged in private practice and are certified Board members.

The objective of the Division's program is to make available all services and resources which will allow, within reasonable limits, all physically handicapped children to reach adult life as happy, well-adjusted, and self-sustaining individuals. In all cases, the Division's program is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division works cooperatively with local medical societies, Illinois Children's Hospital-School, hospitals, civic and fraternal organizations, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis, and other interested groups.

NEW HEALTH SERIES ON RADIO

The Chicago Industrial Health Association, through the sponsorship of Johnson and Johnson, will inaugurate its health radio series, entitled "It's Your Life", on Station WMAQ beginning October 18th. The program will be on the air daily, Monday through Friday, at 11:15 to 11:30 A.M. It is believed that this is the first time that a group of professional and health workers have produced a health series by means of a national commercial sponsor. It is the hope of the Association and the sponsor, if the series proves successful, to broadcast it from stations in other cities, with the possibility of a final national hookup. The original contract runs for 13 weeks, to be extended at the option of the sponsor.

The plan is to include all phases of personal, family, community and industrial health in this series by means of the tape-recording technique, by which the experiences of people in matters of health will be recorded and broadcast using their own words in their own voices. It is believed that this will be a very effective form of approach when coupled with additional comments by the narrator.

VACANCIES UNDER CIVILIAN RESIDENT PROGRAM

To the Editor:—

We would appreciate your publishing the following item in your Society Bulletin.

"The Surgeon General of the Army announced on 21 September 1948, that vacancies exist under the Civilian Resident Program as follows:

Assistant Residents: Obstetrics and Gynecology — 9, Pediatrics — 2, Neuropyschiatry — 4, E.E.N.T. (May be ENT-eye) — 16, Ophthalmology — 2, Otolaryngology — 5, Physical Medicine — 10.

Residents: Anesthesiology — 2, Obstetrics and Gynecology — 1, General Surgery — 8, Cardiology — 1, Allergy — 2, Pediatrics — 7, Internal Medicine — 6, Neuropsychiatry — 5, Clinical Laboratory — 4, E.E.N.T. (May be ENT-eye) — 22, Ophthalmology — 1, Otolaryngology — 10.

Senior Residents: Obstetrics and Gynecology — 3, Neuro-Surgery — 5, Gastro Enterology — 7, Dermatology — 1, Allergy — 1, Pediatrics — 4, Internal Medicine — 12, Neuropsychiatry — 4, Clinical Laboratory — 4, E.E.N.T.. (May be eye — 4.

This Program is designed to provide graduate professional training for physicians who desire a career with the Regular Army Medical Corps. These selected are permitted to remain in their Residency training as officers on active duty with full pay and allowances.

For additional information please contact Surgeon's Office, Headquarters Fifth Army, Bu 8-5800, Extension 216, or Medical Section, Chicago Sub-Office, ISSI, An 3-3600.

Next Medical Reserve Meeting: 1930 Hours, 11 October 1948, Room 511, 226 W. Jackson Blvd, Chicago 6, Illinois.

Signed: The Medical Instructors
Sincerely,
John C. Keele Jr.
Major, MSC
Instructor, Medical OR Units

WARNS OF DANGER IN DISTRIBUTED SOLUTION

The Federal Security Agency's Food and Drug Administration warns physicians and dentists that certain codes of procaine hydrochloride solution manufactured by C. B. Kendall Company, Indianapolis, Indiana, caused severe necrotic damage upon injection. The facts came to light only recently when the American Medical Association informed the Food and Drug Administration that a physician reported injuries from a batch of the solution coded 24830.

This code was placed in distribution in February 1948. C. B. Kendall Company determined, following reports of untoward reactions, that the solution is highly acid, possessing a pH of about 1. The company attempted to recall the lot by a letter dated June 3, addressed to each purchaser of the vials, which directed their return, and by recall efforts of its own salesmen. This recall program has not been completely effective.

The Food and Drug Administation has just learned that another batch of the firm's procaine hydrochloride solution, coded 64712, has caused several alleged necrotic reactions. The pH of a vial of this lot was found to be 2.9.

Pharmacological work being perfomed by the Administration indicates that these two products are dangerous and should not be used. They have been distributed in the area from Florida to Wisconsin and from West Virginia to Texas.

DERMATOLOGISTS TO MEET IN CHICAGO DEC. 4-9

The seventh annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago from Saturday, December 4 through Thursday, December 9.

The principal sessions will be held at the Palmer House, with special courses in Histopathology and mycology scheduled for Saturday and Sunday, December 4 and 5, at the Medical Schools of the University of Illinois and Northwestern University. As in the past two years, teaching clinics will be held on the afternoons of Monday, Tuesday, and Wednesday, December 6, 7, and 8th. A new feature is being added to the program this year consisting of informal discussion groups which will be held at noon and 5:00 P.M. sessions.

Special courses in histopathology, mycology, x-ray and radium therapy, mucous membrane lesions, bacteriology of the skin, industrial dermatoses, specific granulomata, and dermatoscleroses will be held under leaders in these various fields.

MEDICAL CARE FEE SCHEDULE

To the Editor:—

It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the socalled "Home Town Medical Care Program for Veterans." It has been contended that the Veterans Administration has arbitrarily established a Fee Schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a National Fee Schedule. It has also been contended that the various State Medical Societies and other interested groups were not consulted when this Fee Schedule was adopted.

In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a National Schedule of Fees, nor do I contemplate doing so. However, the Fee Schedules originally submitted by the various State Medical Societies, when the "Home Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to estabish a uniform Fee Schedule Format and to set up tentative fees which could be used as a guide by the various State Medical Societies when submitting their proposals for the furnishing of medical care to veterans.

This uniform Fee Schedule Format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This Group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after a careful analysis of Pre-Paid Medical Care Plan, Workmen's Compensation and Insurance Fee Schedule, and also the Fee Schedules in effect in the various States having agreements with the Veterans Administration. As was to be expected, considerable variation occured in the Fee Schedules reviewed.

The Professional Group of National Consultants made every effort to arrive at fees that were considered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between State Medical Societies and Veterans Administration.

Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA", which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the Medical Society concerned.

May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or National Fee Schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

Very truly yours,
PAUL B. MAGNUSON, M.D.
Chief Medical Director

SYMPOSIUM ON MEDICOLEGAL PROBLEMS

A symposium on medicolegal problems is being held under the cosponsorship of the Institute of Medicine of Chicago, the Chicago Medical Society and the Chicago Bar Association, Tuesday evenings, October 26 through November 23, and Thursday, December 2, 1948 at the Chicago Bar Association, 29 South La Salle Street. The series is as follows:

October 26: MENTAL AND CHRONOLOGICAL AGE PROBLEMS IN LAW AND MEDICINE

Presiding: Hon. Harold G. Ward, Judge, Superior Court, Cook County

Medical Presentation: David Shakow, Ph.D., Professor of Psychology, University of Illinois College of Medicine

Legal Presentation: Hon. Joseph J. Drucker, Judge, Boys' Court, Chicago

November 2: SEX OFFENSES AND SEX OFFENDERS

Presiding: William Haines, M.D., Director, Behavior Clinic, Criminal Court

Medical Presentation: Harry Hoffman, M.D., State Alienist and Associate Professor of Psychiatry, University of Illinois College of Medicine

Legal Presentation: Erwin W. Roemer, Esq., of the Chicago Bar

November 9: MODERN METHODS OF CRIME DETECTION

Presiding: E. M. K. Geiling, Ph.D., M.D., Professor and Chairman, Department of Pharmacology, University of Chicago

Medical Presentation: "Truth Serum," Roy Grinker, M.D., Chairman, Department of Neuropsychiatry, Michael Reese Hospital

"Lie Detector," Leonard Keeler

Legal Presentation: Fred E. Inbau, Esq., Professor of Law, Northwestern University

November 16: INCOME TAX DISCRIMINATION AGAINST THE PROFESSIONS

Presiding: Frederick O. Dicus, Esq., of the Chicago Bar

Medical Presentation: Frank G. Dickinson, Ph.D., Director, Bureau of Medical Economics Research, American Medical Association

Legal Presentation: Robert F. Spindell, Esq., of the Chicago Bar

November 23: THE PROBLEM OF ALCOHOLISM: MEDICAL AND INDUSTRIAL ASPECTS

Presiding: Anton J. Carlson, Ph.D., M.D., Frank P. Hixson, Distinguished Service Professor Emeritus of Physiology, University of Chicago

Medical Presentation: Andrew C. Ivy, Ph.D., M.D., Vice President and Distinguished Professor of Physiology, University of Illinois College of Medicine

Industrial Aspects: Edward C. Holmblad, M.D., Managing Director, American Association of Industrial Physicians and Surgeons

Legal Presentation: James J. McKenna, Esq., of the Chicago Bar

December 2: HOW CAN THE CONSTITUTIONAL OFFICE OF CORONER SERVE MODERN NEEDS

Presiding: Hon. John V. McCormick, Judge, Municipal Court

Medical Presentation: Herbert S. Breyfogle, M.D., Chief Medical Examiner, Commonwealth of Virginia

Legal Presentation: Francis X. Busch, Esq., of the Chicago Bar

GERMAN MEASLES DURING PREGNANCY

The First Report of the Joint Committee of the National Society for the Prevention of Blindness and the American Academy of Pediatrics includes 132 mothers who had German measles during the first trimester of pregnancy, and of the babies born of these 132 pregnancies only 18 were normal. Sixty-two weighed less than six pounds at birth; 76 had congenital cataracts; 35 were deaf; 22 were microcephalic and 46 mentally retarded. Malformations of the heart were diagnosed in 67. Disturbances of the eye, other than congenital cataracts in 13, included congenital glaucoma, microphthalmus, chorioretinitis and strabismus. Hyposadias was observed in four, inguinal hernias in four, malformations of the extremities in three, cleft palate in three, harelip in one. There was in the lot one cretin, one mongolian idiot.

The subject should be discussed now in every county medical society, and acted on now.—So. Med. and Surg.

STATE DEPARTMENT OF PUBLIC HEALTH



Program For Prevention of Dental Caries

One of the important new programs sponsored by the State Department of Public Health is the topical application of sodium fluoride to the teeth of children. This program is an activity of the Division of Public Health Dentistry under the immediate supervision of John Chrietzberg, D. D. S.

Out of the past several decades of research on the problem of dental caries, 17 studies by eminent dental authorities in scattered areas of the United States have shown that a 40 per cent reduction in dental caries can be produced by the topical application of sodium fluoride. The use of sodium fluoride in 2 per cent aqueous solution applied topically to the teeth of children for the prevention of dental decay has been approved by the Council of Dental Therapeutics of the American Dental Association and is endorsed by the United States Public Health Service.

Although there is much work to be done on the cause of dental caries, and there remains much information to be had on the exact relationship of sodium fluoride application and the reduction of caries, the evidence to date is so conclusive and the size of the problem of such significance that the Congress of the United States has seen fit to make substantial appropriations for public health dentistry. $2,000,000 was appropriated by the 80th Congress for the construction and equipment of a dental research institute and $750,000 annually for research purposes. In addition, Federal funds to the extent of $1,000,000 were appropriated to enable the Public Health Service "to set up facilities in cooperation with the states, dental societies, and other organizations to demonstrate to the dental profession and the people of America generally, the efficiency of the relatively new procedure of so-called topical application of sodium fluoride to the teeth as a preventative against dental decay."

One demonstration team from the Public Health Service has already been assigned to Illinois to carry out the intent of this legislation and one or two additional teams are expected. Each team, which consists of one dentist, two hygienists, and one clerk, will carry on demon-

stration projects in strategic areas of Illinois. The public and the professions will be invited to see the team in operation.

The procedure consists of a series of four applications of 2 per cent Na F in aqueous solution at the rate of one or two applications per week. The first application of the series is preceded by a cleansing of the teeth. Prior to each application of the chemical, the teeth are isolated with cotton rolls and dried with compressed air. The crown surfaces are moistened with Na F and allowed to dry in air for three minutes. To provide for protection for the permanent teeth during the period of changing dentition, the series of four applications should be repeated at intervals of approxiamtely three years.

Although a great many areas of Illinois have already requested the services of demonstration teams, assignment will be made in accordance with local interest, local health facilities and personnel, low dentist-population ratio, and advantages of the area for demonstration purposes. Any area visited by a team with its portable equipment must assure a case volume of at least 300 children. In order to afford all segments of the State an opportunity to see a team in action, it is unlikely that the stay of any team can exceed three months in any one area.

The intent of furnishing the team-demonstration in an area is not to provide an isolated experience, but rather to stimulate the development of a permanent program of topical application of sodium fluoride to each cohort of children throughout the coming years. The State Department of Public Health encourages, and insofar as possible, will assist local communities in carrying on a long-term project.

In addition to the topical application demonstration team, the Department furnishes, without charge, 2 per cent aqueous solution of sodium fluoride to licensed dentists in the State of Illinois. The Department is also participating in the Evanston, Illinois, project which involves the addition of 1 p.p.m. sodium fluoride to the municipal water supply. The object of this study is to determine if the addition of 1 p.p.m. fluorine to the drinking water will have the same results in inhibiting dental decay as naturally present fluorine in the community water supply. The Evanston study has been set up in cooperation with the Evanston Health Department and is expected to operate over a considerable number of years.

The State Department of Public Health and its Advisory Committee on Dental Health is hopeful that this expanded program of public health dentistry will make substantial advances against the practically universal disease of dental caries.



ORIGINAL ARTICLES



Intrathecal Therapy Contraindicated for Meningitis

Archibald L. Hoyne, M.D.
Chicago

Prior to the culturing of the meningococcus by Weichselbaum[1] in 1887 and the introduction of lumbar puncture by Quincke in 1891, the diagnosis of meningitis during life was almost always based on clinical findings. But now lumbar puncture and examination of cerebrospinal fluid is an essential procedure for accurate diagnosis in nearly every form of meningitis. However, when there are clinical signs of meningitis and especially if petechiae are present, a reliable bacteriologic diagnosis can often be made without examination of the cerebrospinal fluid. This may be accomplished by obtaining a positive blood culture and perhaps also by smear from petechiae. Such findings should mean that the etiologic factor for the meningitis is established. Under these circumstances, if the meningococcus in particular is isolated, a spinal tap is not a necessity.[2] For meningitis due to any other cause it is usually best to make at least one lumbar puncture for a bacteriologic diagnosis.

Until 1906, when Kolle and Wassermann[3] developed an antibacterial serum to combat the meningococcus experimentally, there was no specific therapy for any kind of meningitis. In the same year Jochmann[4] began the intrathecal use of that serum for human beings. Flexner's[5] antimeningococcus serum was first used for the treatment of patients during an outbreak of epidemic meningitis in Akron, Ohio, in 1907. This serum was credited with a reduction in fatality rates by from 30 to 35 per cent. It was not merely recommended that it be administered intrathecally but there was insistence that this route must be followed in order to bring the serum in contact with the organisms in the cerebrospinal fluid. From 1907 for a period of 30 years and as long as antisera continued to be used, its routine application was by means of the spinal needle. Herrick[6], however, did advise large doses of serum intravenously to patients

Presented before the General Assembly of the Illinois State Medical Society, Annual Meeting May 12, 1948, Chicago.

with meningococcemia during World War I. Kolle and Wassermann in 1906, when serum was first developed, also recommended that it be given intravenously.

Adult patients on my service at Cook County Hospital were treated with serum intravenously[7] as early as 1918. Nevertheless, it was not until 1934[8] after our favorable experience with Ferry's meningococcus antitoxin[9] that[10] we adopted exclusive[11]intravenous treatment for meningococcic meningitis. Following the success of this method, intrathecal therapy was no longer used for any form of meningitis on my service.

When the sulfonamides came into general usage for the treatment of meningitis and the adminstration of antisera progressively lessened because of diminished production, those who had adhered to intrathecal therapy soon discarded this route, not from choice but because compelled to do so. For specfiic type antipneumococcus serum also became as difficult to secure as antisera for meningococcic infections. But the opportunity to put into effect the favored technique was not lost permanently for shortly type B anti-influenza rabbit serum[1,2] was developed and then penicillin and finally streptomycin were introduced. As the value of each one of these last three therapeutic aids became firmly established for definite kinds of meningitis, emphasis was placed on their administration intrathecally. In fact the word "must"[13] has often been used just as it was in earlier days when general opinion dictated that antimeningococcus serum be injected into the spinal canal every 24 hours or at lesser intervals.

Since 1934 we have treated successfully without intrathecal therapy several thousand patients with meningitis at Cook County Hospital and Municipal Contagious Hospital. Included in the number were cases of meningitis caused by one of the following organisms: meningococcus,[14] pneumococcus,[15,16] Hemophilus influenza[15,16] hemolytic streptococcus, hemolytic staphylococcus aureus,[15] streptococcus viridans, and Friedlander's bacillus. The ages of our recovered patients have ranged from three days to 73 years.

Thus far, in my discussion I have reviewed briefly the history of some of the specific therapeutic measures for meningitis. Another matter for consideration is drainage of cerebrospinal fluid for the purpose of relieving intracranial pressure and also in order to determine by examination of the fluid the patient's prognosis. It is not such a great many years ago that special needles were devised to permit continuous drainage. This was because of the great fear that clinicians often attached to the possibility of deleterious effects from intracranial pressure. Some recommended the use of a Bradford frame when instituting such a method. In the days to come, if not now, perhaps the latter procedures will be regarded as barbarous.

We believe we have demonstrated conclusively that frequent lumbar punctures[17] for drainage are not beneficial for the patient. In reality, multiple taps seem to have the effect of stimulating the secretion[18] of cerebrospinal fluid. As a consequence, the patient complains far more of headache than when but a single puncture or none at all has been made. For 727 menigococcic patients[19] our average number of lumbar punctures was less than one. This was possible because 218 patients had no intrathecal tap. The fatality rate, including 20 with the Waterhouse-Friderichsen syndrome and all patients admitted to hospital in a moribund condition, was 14.8 per cent. Among 22 patients of the series who were given penicillin intraspinally in addition to sulfonamide therapy there were 9 deaths or a mortality of 40.9 per cent.

Punctures for the purpose of examining the cerebrospinal fluid to determine the patient's prognosis are of distinct scientific interest. However, it would seem as though anyone with experience could decide on clincal findings alone whether the patient was gaining or losing in his struggle for recovery. Practically, resort to repeated punctures as an index to prognosis is not required. Moreover, an operation which does not promote the welfare of the patient is better omitted. When caring for meningitis, as I have commented on innumerable occasions, it is the patient we are treating not just the spinal fluid.

Any procedure which adds to a patient's discomfort, is attended by hazards, no matter how slight, and is not necessary from the standpoint of efficient treatment, should be contra-indicated. If that statement is undeniable and we have proof that it is correct when applied to meningitis, then the question of intrathecal treatment and multiple taps for drainage or prognostic purposes should be settled. Unfortunately, it is only those who have adopted our methods[20] of

treatment who are convinced of our assertions, notwithstanding the evidence available. There are still many who refuse to discard old methods, decline to accept measures of proven efficiency and yet report the disadvantages of the procedures they practice.

Even if one were to maintain that fatality rates are just as low with intrathecal treatment as without, any claim of preference for intrathecal therapy is not acceptable. When a foreign substance is introduced into the intrathecal sac it causes an irritation of the meninges. In other words, meningitis can be produced in this manner. Many times when remedies have been injected into the spinal canals of patients with meningococcemia who had no evidence of meningitis, resulting meningitis has occurred. The presence of substances in the cerebrospinal fluid is influenced primarily by two things. These are the concentration of those substances in the blood stream and the permeability of the barrier. An individual may have meningococci in meningitis. Following the success of this method, the blood stream and not have meningitis. Under such conditions the spinal fluid may be normal. But after an irritating substance, whether serum, penicillin, or some other remedy is given intrathecally, the meninges are irritated, their permeability is increased and meningococci appear in the spinal fluid together with all of the other customary findings of meningitis. Moreover, the clinical evidence of meningitis becomes apparent. Rigidity of the neck is observed and this may progress to a definite opisthotonos. There is an increase in the secretion of cerebrospinal fluid, and if the patient is rational, headache frequently is bitterly complained of. Without intrathecal treatment it is unusual to have headache mentioned after the first twenty-four hours of therapy unless punctures are being repeated for drainage or for numerous examinations of spinal fluid. When serum was used intraspinally organisms often persisted in the cerebrospinal fluid for several weeks, whereas, when given exclusively by the intravenous route, in large doses, the spinal fluid sometimes became sterile within 72 to 96 hours.

Penicillin when given intrathecally sufficiently often may eradicate organisms from the spinal fluid but its application in this manner is not necessary. Futhermore, besides the ordinary disadvantages of administration, it is attended by elements of danger, some of which have been reported. Transverse myelitis and subarachnoid hemorrhage are among the accidents that have followed intrathecal administration. Moreover, good results are generally attained for meningococcic infections with the sulfonamides alone.[14] For meningitis due to pneumococci and other organisms where penicillin is indicated, the intramuscular route is satisfactory if sulfonamides are also prescribed.

When streptomycin first became available, it was stated, and the assertion is continually repeated, that this drug should[21] be given intrathecally when used for influenzal meningitis. Nevertheless, we have treated approximately 50 influenza meningitis patients with streptomycin by the intramuscular route without any intrathecal therapy. Twenty of these have been reported among a group of 30 influenzal meningitis[22] patients who had no intrathecal treatment: there were two deaths, or a fatility rate of 6.6 per cent. These results were with consecutive patients and do not constitute assembled numbers who were treated at various times. Moreover, one of the two fatalities occurred a few hours after the child entered the hospital. We know of no similar group with as low a fatality figure. Yet while others continue to inject streptomycin intrathecally they report bad reactions and even admit that because of unpleasant effects their favorite route must sometimes be discontinued.

When we adandoned intrathecal therapy in 1934 the number of complications customarily observed with meningococcic menigitis during former years dropped sharply. There was scarcely any more loss of vision, less deafness, and hydrocephalus became almost unknown. Nearly all these improvements[23] now are attributed generally to the sulfonamides and none to the discontinuance of intraspinal serums.

Writers have affirmed[24] that serious reactions following intracisternal and intraventricular administration of penicillin as well as complications of its intrathecal lumbar injection have been accumulating in the literature. And "in spite of these reports one still finds widespread ignorance of the toxic reactions to the intrathecal use of penicillin." The same authors might have added quite properly that one also still finds widespread ignorance of the good results obtained

without any intrathecal treatment for all forms of meningitis. For many years we have called attention to disadvantages of intrathecal treatment and reported good results without this form of therapy. Nevertheless, as each new remedy for meningitis appears the same old urge to apply it intrathecally is manifest. Even severe reactions, serious complications, and possibly death are not a cause for dismay.

The accidents and complications resulting from intrathecal penicillin are by no means all new to intrathecal therapy. It is unfortunate that so few have yet been convinced that intrathecal therapy is not merely unnecessary but may prove to be dangerous. However, intrathecal penicillin may be a factor to bring about the final awakening.

Among the complications reported from the intrathecal use of penicillin have been spinal blocks,[25] just as occurred so often with intrathecal antimeningococcus serum. Blood tinged spinal fluid, hemiplegia, transverse myelitis,[26] thrombosis of spinal veins[25] complete obliteration of subarachnoid space, shock, coma, and death have been reported. In some of these cases intraspinal penicillin was continued even after the complications occurred. Sweet[27] in citing four instances of reactions to intraspinal penicillin, states the lesions involved the lower segment of the spinal cord or roots of the lumbosacralplexus. Most reactions to intrathecal penicillin have occurred between the tenth and fourteenth day after administration.

One of our patients at Cook County Contagious Hospital had five attacks[28] of meningitis within five years. The first four times he was treated successfully without intrathecal therapy. On the fifth occasion he received penicillin intrathecally for four consecutive days and died of extensive subarachnoid hemorrhage. Four of the attacks were due to different types of pneumococci and one to H. influenzae.

Intrathecal penicillin may cause headache and convulsions. Neymann[29] has observed that intraventricular and intracisternal penicillin may induce a status epilepticus with a fatal outcome. Other complications reported are arachnoiditis, and also necrosis[29] of central portion of spinal cord, probably due to decreased blood supply which may result from thrombosis of vessels.

COMMENT: Objections to intrathecal therapy are as follows:

1. Causes the patient discomfort and pain.[30]
2. Has tendency to produce opisthotonos.
3. Uncertainty that the amount of remedy injected is sufficient to control the infection.
4. Repeated spinal punctures increase the chances of introducing secondary infections.
5. Possible injuries to intervertebral disks which may result in permanent disability.[31]
6. May cause hemorrhage or thrombosis of vessels, resulting in degenerative changes in spinal cord.
7. Sometimes responsible for adhesions, blocks, and hydrocephalus.
8. Slower recovery.
9. Greater likelihood of relapses.
10. Does not lower fatility rates.
11. The procedure is unscientific because it has no advantages and is accompanied by hazards.

On the basis of experience acquired in two contagious disease hospitals during a number of years, there seems to be no justification for treating meningitis intrathecally. Under any circumstances the objections to intrathecal therapy far outweigh any possible benefits.

3026 S. California Avenue

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The Differential Diagnosis Of Poliomyelitis

Henry W. Woltman, M.D.,
Department of Neurology and Psychiatry, Mayo Clinic,
Rochester, Minnesota

An epidemic of poliomyelitis is almost unparalleled in viciousness, and scarcely a summer passes without an outbreak of this disease. Our only comfort lies in the helping hand now given to its victims; our inspiration, their great courage; our hope, the knowledge that a fight is on to end this scourge.

Leading the fight and observing the best traditions of medicine, The National Foundation for Infantile Paralysis has given every citizen his job. Until the disease can be prevented, ours is to treat the patient. But, before we can do so, we must recognize this disease and exclude others.

The final evidence in diagnosis of an infectious disease is a demonstration of the causative organism. In virus diseases, however, the technical difficulties involved in furnishing such proof are so forbidding to the average clinician that he must be content to rest his case on less specific evidence. This is true of the diagnosis of acute anterior poliomyelitis. In making the diagnosis of this disease the physician is guided by a concatenation of ever-changing signs and events: evidence of acute infection; season of the year; existence of other cases of poliomyelitis; symptoms and signs of meningoradicular irritation, nystagmus, tremor, evidence of damage done, in hours or days, to scattered groups of lower motor neurons of cord and medulla with general sparing of other neuronal systems, particularly of sensation, and evidence given on examination of the spinal fluid. No one of these observations, in and by itself, suffices to justify the diagnosis of poliomyelitis. During an epidemic, suspicion is easily aroused by events that ordinarily attract little attention: By headache, a backache or an ache anywhere; mild fever; a cold; a gastrointestinal upset, or behavior precipitated by anxious parents or symptomatic of the end of vacation and the prospect of school and books. At some other time of year the physician surveys the situation with serenity, even though he is aware that poliomyelitis does occur in the odd season and even though his patient may exhibit a cardinal sign of the disease, muscular paralysis.

Read at the 108th Annual Meeting of the Illinois State Medical Association, Chicago, Illinois, May 10, 1948.

TABLE 1

THE DIFFERENTIAL DIAGNOSIS OF POLIOMYELITIS IN THE PREPARALYTIC PERIOD

Disease	Fever	Meningeal irritation	Spinal fluid Cells*	Spinal fluid Protein	Spinal fluid Organism	Tests
Poliomyelitis	+	+	P L	±		
Choriomeningitis	±	+	L(P)			Complement fixation; mouse; neutralization
Encephalitis						
Lethargic	±	±	L(P)	±		
St. Louis	+	+	P L	±		Complement fixation; neutralization
Equine	+	+	P L			Complement fixation; neutralization
Lymphogranuloma venereum	+	+	L			Complement fixation; mouse; Frei test
Acute purulent meningitis	+	+	PPL	+	+	
Tuberculous meningitis	+	+	LLP	++	+	
Torula	+	±	L P	+	+	
Toxoplasmosis	+	+	L P	±	+	
Typhus; Rocky Mountain spotted fever	+	+	L P	+		Complement fixation; guinea pig; agglutination
Measles; chickenpox; mumps; vaccinia; whooping cough	+	+	L P	±		
Trichinosis						Biopsy

*P means polymorphonuclear leukocytes; L, lymphocytes.

For my present purpose, I shall disregard the month.

DIFERENTIAL DIAGNOSIS IN THE PREPARALYTIC PERIOD

Early and accurate diagnosis will become the most important duty of clinicians when they shall have at hand some method of treatment that will keep paralysis from coming on. The preparalytic stage of poliomyelitis is a crucial period, for the public must be protected and the patient must be treated promptly. But, I shall not tarry long to discuss the differential diagnosis in this period (table 1) since it has been done often and well and particularly so by Lewin[1] in his book on infantile paralysis. Suffice it to say that the preparalytic period is no time to gloss over the history of the illness, to be content with a perfunctory general physical examination, to neglect a neurologic examination, to dispense with laboratory tests and to sleep soundly until morning. Every hint of acute infection and of involvement of the nervous system must be regarded seriously for life is threatened, whether by meningitis, myelitis, encephalitis or poliomyelitis. The danger lies more in failure to examine the patient from head to foot and less in lack of knowledge of these diseases.

DIFFERENTIAL DIAGNOSIS IN THE PARALYTIC PERIOD

Since paralysis is the most urgent, frightening and sinister event in poliomyelitis, let me confine my further remarks on differential diagnosis to the setting in which this symptom occurs. One or another of two situations obtains: either the paralysis is of recent occurrence or it has been in existence for a long time.

Inevitably concern is greater when the patient's muscles are becoming paralyzed. The various conditions listed in table 2 must be distinguished.

Epidemic parotitis.—I shall begin with a disease that may be complicated by rapidly oncoming paralysis of one or more limbs or muscles elsewhere with or without loss of sensation, by fever, signs of meningeal irritation and cellular

changes in the spinal fluid. These complications may, but usually do not, suggest poliomyelitis, since they generally occur with, or shortly after, swelling of a parotid gland or testis. Unfortunately involvement of the nervous system may precede the mumps and, occasionally, parotitis or orchitis may be missing altogether. The presence of an epidemic usually makes possible identification of the nature of these conditions. The pressure of the spinal fluid usually is increased in cases of epidemic parotitis in which complications referable to the nervous system are present and in most cases the cell count in the spinal fluid is high. Neutrophils are present but on the whole the cells are of the lymphocytic variety.

Carcinomatous meningoradiculitis.—A similar picture of rapidly advancing paralysis, that, within a few days, may require the use of a respirator, may accompany growth of metastatic lesions in the nerve roots and meninges; the metastasis perhaps may be from a carcinoma of the lung, a breast that is already missing or even from an otherwise asymptomatic tumor of the brain. Fever may be present and sensory changes may be minimal. When such metastatic growths are present, the concentration of protein in the spinal fluid often is markedly increased, and in addition lymphocytes and neutrophils are found often and sometimes malignant cells are found.

Periarteritis nodosa.—Before paralysis occurs in a patient who has periarteritis nodosa, he usually has been ill for some time, but if the paralysis, which is often rapid in onset, occurs early and is unattended by the usual sensory changes, poliomyelitis might be considered. Periarteritis nodosa may progress steadily but more often it advances episodically in different locations. This apparent concurrence of more than one serious ailment in the same patient should suggest the possibility of periarteritis nodosa. Leukocytosis is present in 32 per cent of cases of periarteritis nodosa. Eosinophilia is a strong indication of periarteritis but found in only 12 per cent of the cases.

Neurologic symptoms usually are marked by paralysis of one or more isolated peripheral nerves, especially those of the upper and lower extremities; the clinical picture usually is referred to as mononeuritis multiplex rather than as multiple peripheral neuritis. The spinal fluid may be under increased pressure and may exhibit xanthochromia, increased concentration of proteins and pleocytosis. The diagnosis also may be made on biopsy of some inflamed structure.

In most other diseases, which must be distinguished from poliomyelitis in the paralytic period that I shall discuss, the paralysis is not accompanied by an increase in the number of cells in the spinal fluid, a feature that is of decided help in differential diagnosis.

Neuronitis or the Guillain-Barré syndrome.—A disease of unknown causation that may reach epidemic proportions and that recurrently has suggested some unusual type of poliomyelitis is febrile polyneuritis, the Guillain-Barré syndrome or, briefly, neuronitis. Like poliomyelitis, neuronitis often follows an acute febrile illness from which the patient may seem to have recovered. Presently there appears a rapidly progressing motor paralysis of the extremities, in which the proximal muscles of the limb are often, but not necessarily, weaker than are those of the distal parts of the limb. The lower extremities are usually affected more severely than the upper and with increasing weakness the tendon reflexes disappear. In about 35 per cent of cases, there is also paralysis of one or both facial nerves. The patient may complain of regurgitation, the muscles of mastication may be weak, and diplopia may be present. Function of the vesical and anal sphincters may be impaired. Paralysis may become so severe that a respirator is needed.

All I have said thus far might have been said also of poliomyelitis. The muscle weakness of neuronitis tends to be diffuse and symmetrical, whereas in poliomyelitis it is often insular and asymmetrical. Sensory loss is often minimal and may be overlooked, but if present, serves as a further distinctive bit of evidence in favor of neuronitis. A fairly constant feature is excessively high concentration of protein in the spinal fluid. Pleocytosis is usually altogether lacking, but even this may occur in poliomyelitis. Recovery may take place within a few months or two years, and when it occurs, it is usually complete although the mortality rate was 14 per cent in a series of 35 cases which have been reported.

Diphtheritic Polyneuritis.—Occasionally diphtheritic paralysis enters into the differential

diagnosis of poliomyelitis. As a rule the initial infection and paralysis of the soft palate and of accommodation call attention to the probable cause of the disorder, but sometimes paralysis begins in the extremities and involves the palate later. More commonly four to six weeks pass after development of paralysis of the palate before paralysis of the extremities appears, but it may be delayed as long as four months. In the meantime the patient may have resumed his work, thinking himself to be well. Weakness may affect the proximal muscles as much as the distal muscles. Practically no cranial nerve is spared from the possibility of involvement, and sometimes the sphincters are included in the paralysis. Ataxia is striking and often appears early. In the spinal fluid, as in neuronitis, the concentration of protein may be elevated, but the cell count remains normal. Often the Corynebacterium diphtheriae may still be demonstrable in the faucial secretions; the finding of this organism, of course, is of great help in establishing the diagnosis.

The resemblance of the disorders that will be considered subsequently to those that have been described may be close, but examination of the spinal fluid usually discloses neither an increase in cells nor in protein.

Acute porphyric neuritis.—A serious disorder that has not received the attention it deserves is acute porphyric neuritis. The initial symptom is almost always pain in the abdomen and this too frequently leads to abdominal exploration. The patient may give, usually on direct questioning, the history of having passed reddish or brownish urine; this color change is hastened by the exposure of the urine to sunlight or ultraviolet light. In the presence of uroporphyrin, a pinkish fluorescence occurs under ultraviolet light.

Usually the pulse is rapid, and blood pressure increased. Fever may or may not be present. In 50 per cent of cases in which abdominal symptoms occur, the nervous system becomes involved. The distribution of the paralysis of the limbs may suggest the Guillain-Barré syndrome, but in other cases, as in poliomyelitis, it is often asymmetrical and spotty, and pain and "spasm" may occur. Sensory disturbances are less prominent than are motor disturbances. Retention of urine may be a feature. The cranial nerves may be involved. Examination of the spinal fluid usually has given negative results.

Landry's paralysis.—The designation, "Landry's paralysis," has come to mean a rapidly ascending flaccid paralysis with loss of tendon reflexes, preservation of sensation and of sphincteric control, normal spinal fluid and no discoverable pathologic change in the spinal cord. Cases of this type are encountered, and in respect to tradition may be called "Landry's paralysis," but they are unlike the 10 cases Landry described in 1859. Some commentators suggest that his were cases of beriberi; others, that he gave as good a description of neuronitis as any author of that day might have attempted.

The following case might be classified as a case of Landry's paralysis:

An insurance salesman, aged 48 years, was brought to the Mayo Clinic on the afternoon of October 5, 1942. In 1901, when he was 7 years of age, he had had an attack of poliomyelitis which left him with weakness and atrophy of the right leg.

A week before this patient came to the clinic he had had an almost unnoticed coryza. On October 3, he had witnessed a football game. On the evening of October 4, the right hand had felt somewhat weak when he tried to cut his salad, and at the time that he went up the stairs to bed, the left lower extremity felt heavy. On the morning of October 5, he experienced difficulty in shutting off the alarm clock, and when he attempted to get out of bed, his lower extremities were so weak that he could not stand. As the day progressed, so did his weakness and by midafternoon, when he arrived at the hospital, he was unable to move the lower extremities and could barely move the upper extremities. All tendon reflexes were absent, sensation was normal, there were no signs of meningeal irritation, and his temperature was normal. On October 6, he was unable to cough. The sphincters were normal. Consciousness was clear. The administration of prostigmine was without effect. Examination of the spinal fluid showed a content of protein of 40 mg. per 100 cc. and 1 cell per cubic millimeter. On October 7, the patient was placed in a respirator. On October 9 he could no longer swallow and on October 10, six days after the onset of the paralysis, he died.

Examination of the spinal cord disclosed only the residuals of an old poliomyelitis in the lumbar region, otherwise it was entirely normal.

Subsequently it was learned that this patient had been sent a duck which he had eaten on the evening of October 3. No other member of the family had partaken of it. The possibility of botulism was considered but could not be proved. The case was classified as Landry's paralysis of unknown cause.

Botulism.—A serious and often fatal paralysis that is sometimes misdiagnosed poliomyelitis, particularly if it occurs in an isolated case, deserves mention, even though it is rare. Overwhelming prostration occurs. Then follows paralysis of the throat, tongue, face, extrinsic and intrinsic muscles of the eyes and of respiration. Meanwhile consciousness remains intact. The pulse is usually rapid, the saliva is tenacious, and functions of bladder and bowel are at a standstill. In a third of the cases, however, there may be signs of irritation such as vomiting, diarrhea and abdominal pain. The spinal fluid is normal. Since more than one person generally becomes ill, the inquiry turns to what may have been eaten. I am referring, of course, to the toxin generated by the Clostridium botulinum. This toxin exerts a curare-like action on nerve endings of striated and nonstriated muscles. The presymptomatic interval may range beyond a hundred hours, and the illness may run its course in from twelve hours to a week. The prognosis is bad, as about two thirds of the patients die. Recovery of the others may be long and tedious.

Tick paralysis.—The possibility of tick paralysis is easily overlooked. This is not presumed to be a virus disease and the action of the etiologic agent, whatever it is, still is not understood. It is reported in the western part of the United States, the Carolinas, Georgia, New York, Kentucky, Texas, British Columbia, South Africa and Australia. Young persons are usually affected. For some unexplained reason, the bite is not felt. The patient may retire in normal health, and on attempting to get out of bed may fall in a heap onto the floor. Usually the paralysis is progressive and extends from the lower extremities upward. It may involve the thorax and the muscles of deglutition and phonation, and it may result in death. The paralysis may be associated with ataxia, numbness of the hands and toes, retention of urine and incontinence.

The tick is usually found somewhere along the spinal column, frequently at the hairline. After removal of the tick, recovery takes place within a few days.

Triorthocresyl phosphate posisoning.—The medical profession was introduced to jake paralysis in 1930, when an extract of Jamaica ginger became contaminated with triorthocresyl phosphate. Subsequently a similar condition was reported in Europe; this time it was due to contaminated apiol, or parsley camphor, which had been used as an abortifacient. The most recent epidemic, 1946, was recorded in England[2] where housewives used a cottonseed oil for cooking. The same triorthocresyl phosphate turned up as cause of the paralysis. Dull aching pain in the calves often occurred from two to ten days after the poisoning. This was accompanied by progressive flaccid paralysis, particularly of the feet, legs and thighs, and not infrequently of the upper extremities. In some cases the medullary bulb was involved. Numbness, if present, was usually transient and sensation was not greatly altered. Disabling residual effects resembling those of poliomyelitis, however, often remained, especially in the lower extremities.

Administration of some of the discarded sulfonamide preparations was followed by similar complications.

Polyneuritis recurrens.—A paralysis of arm, leg or various cranial nerves may appear abruptly as an expression of an uncommon and as yet unexplained disorder known as "polyneuritis recurrens." A disturbance in sensation may be associated and the resemblance of polyneuritis recurrens to serum paralysis is often close. The name indicates its most impressive characteristic, that of recurrence. Other members of the family may suffer from the same affliction and sometimes under the same circumstances, that is pregnancy or the menstrual cycle. But there is always a first attack, and this one may suggest the possibility of poliomyelitis. A case previously reported by Maisel and me[3] is illustrative. The report follows:

A woman, aged 31 years, presented herself at the clinic April 30, 1934, with the complaint of weakness of both lower extremities. Four and a half months before admission and six weeks before the birth of a third child, the patient had had severe right renal colic, which was followed on the next day by hematuria and the passage of small calculi. Two days after this attack and over a period of three or four days, the right lower extremity became completely paralyzed, the left one weak, but not completely useless. The muscles of the back and abdomen became involved also, so that the patient was unable to sit up in bed. There were moderately severe, fleeting pains in both the arms, which, however, did not become weak. During the pregnancy there had been neither vomiting nor any gross dietary deficiency. After delivery, the left leg became much stronger, the back and abdominal muscles

became slightly stronger, but the right leg remained paralyzed.

Examination at the clinic gave essentially negative results save that the muscles of the back and abdomen were markedly diminished in strength, those of the left thigh were moderately weak, those of the left leg slightly weak, those of the right thigh very weak, and those of the right leg completely paralyzed. The muscles of the right leg were moderately atrophied. The patellar reflex was absent on the right and was just obtainable with reinforcement, on the left. The Achilles tendon reflex was absent on the right and normal on the left.

Plantar responses were normal. Sensory examination gave normal results. The spinal fluid was normal; the content of protein was 40 mg. per 100 cc.

Further inquiry revealed that six weeks before the birth of her first child, in 1929, this patient had experienced a "funny sensation" in both arms, which seemed to be weak. The condition had cleared up immediately after the birth of the child. Six or eight weeks before the birth of the second child, in 1931, the same symptoms had developed in her arms, although in addition she now had had numbness and tingling in her legs, which at times had suddenly buckled under her. Again all symptoms had disappeared completely after the child was born. The condition was classified as "neuronitis of pregnancy." It could also have been called "recurrent paralysis."

Familial periodic paralysis.—The first attack of familial periodic paralysis may cause consternation in the family. Since these attacks are usually of short duration, this disorder is seldom confused with poliomyelitis. Occasionally, however, an attack will last for a week or more, and when this occurs, the question of poliomyelitis does arise. The attacks are of more frequent occurrence in young persons than those at other ages. These attacks may come on while the patient is asleep or at any other time. In the regions in which the paralysis obtains, tendon reflexes and electric excitability of the muscles may be absent. The value for serum potassium may be low. Otherwise the patient is comfortable and really looks too well to have poliomyelitis.

Hyperthyroid crisis.—Muscular weakness, that may come on within twenty-four or forty-eight hours, may become so marked that gravity cannot be overcome by the greatest effort, and may be so convincingly suggestive of poliomyelitis that spinal puncture may be carried out, is sometimes associated with hyperthyroid crises. The tendon reflexes may appear to be absent, since they may be so fast that they coincide with shock of the reflex hammer. Here, however, the resemblance to poliomyelitis ceases.

Tumor of the brain.—It scarcely seems possible that a tumor of the brain may give rise to symptoms that suggest the possibility of poliomyelitis. On one occasion I saw such a patient.

The patient was an elderly man who presented himself November 7, 1933, because his left arm dangled helplessly at his side. The history he gave was somewhat vague. The weakness had apparently come on rapidly, within about three days, late in October. The limb was hypotonic and flail; however, the tendon reflexes, although feeble, still could be elicited. It seemed likely that the lesion was situated in the cervical part of the cord, on the left side. Three weeks later, the left side of the face and the left lower extremity were also weak, and it was proper to consider a lesion of the internal capsule on the opposite side of the brain. Two months after the patient was first seen, jacksonian attacks occurred in the helpless arm and three weeks after this he passed away. A spherical glioblastoma, about 2 cm. in diameter, was found in the right internal capsule.

Hysterical paralysis.—Hysterical paralysis or malingering, especially when it occurs in a young child or when there is unwillingness on the part of the child to move a painful extremity, often causes great anxiety, particularly if it occurs in the late summer or early fall. Careful observation usually discloses the nature of the disability.

Poliomyelitis complicating injury.—A particularly confusing situation arises when poliomyelitis is superimposed on an already injured and weakened limb.

On June 24, 1921, a child, aged 2½ years, became entangled in a rubber hose, fell and fractured the left femur. In September, ten days after the cast had been removed, soreness of her limb was ascribed to her energetic playing. It was expected after removal of the cast that this extremity would be somewhat atrophied and weaker than its fellow. On the following day, however, weakness that could not be attributed to the fracture and disuse was noted, the patellar reflex was absent and the rectal temperature was 101° F. Serum for poliomyelitis was administered. Lumbar puncture on the following day revealed 280 cells per cubic millimeter of spinal fluid.

Eternal vigilance is also the price in the diagnosis of poliomyelitis.

DIAGNOSIS IN RETROSPECT

A diagnosis of poliomyelitis must sometimes be made in retrospect. Differential diagnosis is simplified by noting that the wasted muscles of poliomyelitis are often situated asymmetrically. Thus one foot and the opposite shoulder may appear deformed and partially paralyzed. If

TABLE 2

THE DIFFERENTIAL DIAGNOSIS OF POLIOMYELITIS IN NEUROPARALYTIC PERIOD

Disease	Fever	Meningeal irritation	Paralysis	Sensory involvement	Spinal fluid Cells*	Spinal fluid Protein	Tests
Epidemic parotitis	+	+	Local	±	L P	+	Complement fixation
Carcinomatous meningo-radiculitis	±	±	Local	±	LPM	+	Malignant cells
Periarteritis nodosa	+	±	Local; symmetrical	±	LPB	+	
Neuronitis	±	±	Local; symmetrical	±	—	++	
Diphtheritic neuritis	±	—	symmetrical	±	—	±	Culture
Porphyric neuritis	±	—	Local; symmetrical	±	—	—	Urine
Landry's paralysis	±	—	symmetrical	—	—	—	
Botulism		—	Symmetrical	—	—	—	Food
Tick paralysis	±	—	Symmetrical	±	—	—	Tick
Triorthocresyl phosphate poisoning	—	—	Local; Symmetrical	±	—	—	
Polyneuritis recurrens	—	—	Local	±	—	—	
Familial periodic paralysis	—	—	Symmetrical	—	—	—	Low serum potassium at times
Hyperthyroid crisis	—	—	Symmetrical	—	—	—	
Brain tumor	—	—	Local	±	±	±	
Hysterical paralysis	—	—	Local; Symmetrical	±	—	—	

*L stands for lymphocytes; P, polymorphonuclear leukocytes; M, malignant cells; B, erythrocytes.

sensation is normal and if it can be learned that the disability was abrupt in onset or more extensive at that time than at present, and if it can be ascertained also that the disability came on during the summer or early fall, then there is usually little difficulty in identifying the disease.

Cerebral palsy of childhood.—Certain residuals appear to be more confusing than others. A condition that parents often refer to as poliomyelitis or infantile paralysis is cerebral palsy of childhood. The causes of this include cerebral birth injury, anoxia, developmental defects and encephalitis. Frequently the involvement is confined to one side of the body, and the wasting, if any, is not great and is uniformly distributed. Movements may be slow and dystonic, the tendon reflexes are usually increased, sensation is intact, and Babinski's sign is positive.

Congenital anomaly.—A congenital absence of muscles is sometimes interpreted as the residual of poliomyelitis. Any muscle or group of muscles may be missing. Often deformities, such as absence of a breast, a partially developed finger, or inability to rotate the eyeballs properly, are associated.

A deformity of the scapula, known as "Sprengel's shoulder," may suggest the winging caused by paralysis of muscles of the shoulder girdle.

Myelodysplasia.—The clawfeet and "canary" legs of myelodysplasia, a faulty development of the lower end of the spinal cord, are sometimes interpreted as residuals of poliomyelitis. This deformity is closely related to spina bifida, but there may be no hint of it unless it be a sacral dimple or a patch of hypertrichiasis. Roentgenograms of the spinal column often show the occult variety of the defect.

Heredofamilial degenerative disease.—Lower extremities of the extraordinarily chronic Charcot-Marie-Tooth or peroneal atrophy or of Friedreich's ataxia are somewhat similar to those in cases of myelodysplasia. The progress of these degenerative diseases may be so slow that they seem almost stationary. Other members of the

family who bring the patient may be unaware of having the same disorder themselves.

SUMMARY

The differential diagnosis of poliomyelitis concerns the disease from onset to residua. In its most practical applications the differential diagnosis must be tripartite. First and foremost, the diagnosis must be made in the febrile neuroirritative period, when various types of meningitis, encephalitis and myelitis move into focus (table 1). Then, since not all patients are seen early, comes the differential diagnosis in the course of the neuroparalytic period. At this time the physician's chief concern is with rapidly oncoming muscular paralysis and pseudoparalysis, of various kinds and many causes (table 2). Eventually, a diagnosis must be made by retrospection. The making of this diagnosis involves consideration of paralytic residuals of nonpoliomyelitic origin, developmental anomalies and neurodegenerative diseases of such imperceptible progression that their sudden discovery belies their long existence. In the differential diagnosis in any period it should not be forgotten that poliomyelitis may complicate any physiologic event, such as pregnancy, or some other disease or injury.

The urgency of poliomyelitis removes its differential diagnosis from the realm of an academic exercise. Its diagnosis must be conceived, formulated and delivered at the bedside. Therein, exactly, lies our responsibility as physicians.

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New Method Of Cholecystenterostomy

Carl Werelius, M.D.
Chicago

The indications for cholecystenterostomy have increased in the past few years with the advent of radical pancreatic surgery. The consensus of opinion favors a large anastomosis and as that increases the danger of passage of foreign material into the gall bladder, various more or less complicated methods have been devised to shield the opening between the gall bladder and the intestine. With this in mind a semi-oval flap was cut through the intestinal wall, which when turned into the bowel will cover the opening into the gall bladder. We had intended to cut a flap with the free end pointing downwards with the expectation that the downward intestinal current would aid the flap in covering the anastomotic opening but then we reasoned that very likely reverse peristalsis would have the opposite effect. Consequently we used a lateral flap which places it in the same relative position to the current, be it distal or proximalward. In addition, we reasoned that in sewing a curved edge to a straight one it would cause a certain amount of puckering of the redundant mucosa overlapping the edge of the valve thus aiding it in its protective action.

From the Department of Anatomy of the University of Illinois. Read by invitation before the Chicago Surgical Society, November 7, 1947.

The duodenum was used for the anastomosis because in the dog it is freely movable and can be attached to the gall bladder without the slightest tension. For the same reason the jejunum in man will be used most frequently in the future as a gall badder outlet.

The method to be described is a relatively simple procedure.

TECHNIC

So as to simulate the condition for which this operation is done the common duct in each dog was tied and cut between two silk ligatures.

Step one: The gall bladder is attached to the duodenum with an interrupted or continued sero-serous suture fairly close to the mesentery of the bowel as in Fig. 1,A. At times it is desirable

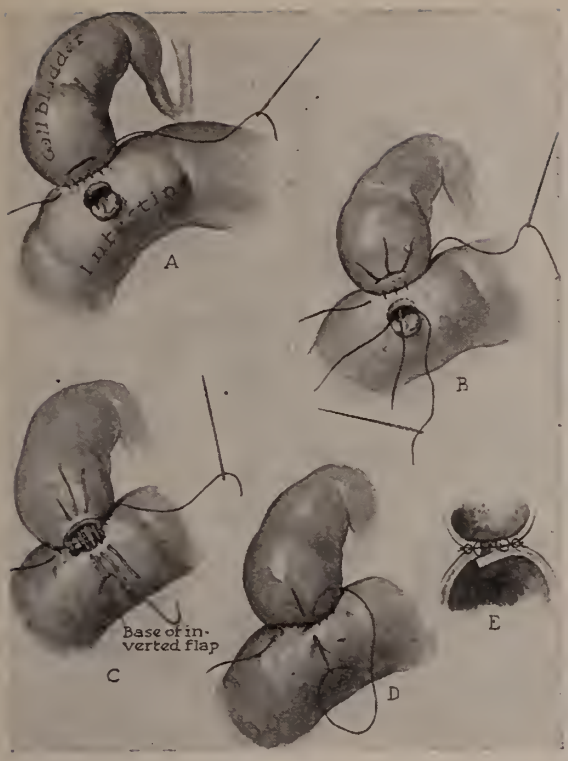


Figure 1





Figure 2A (Top) and 2B

to detach the gall bladder from the liver so as to obtain space for the anastomosis.

Step Two: A semi-elliptical incision is made through the intestine with the convexity towards the gall bladder. As the flap is cut it curls upward out of the intestine and bleeds very slightly. However, in order to definitely insure haemastasis of the cut edge of the flap and to prevent adhesions to its sides, we ran a continuous fine silk suture along the entire edge of the flap.

Then a second straight incision is made through the gall bladder wall opposite the intestinal opening, Fig. 1,B.

Step Three: The flap is kept protruding out of the bowel and concave cut edge of the duodenal incision is sutured to the edge of the gall bladder incision nearest to the intestine by interrupted sutures. This procedure is facilitated by first applying a suture in each angle and a guy suture in the middle of the edges to be sewed, Fig. 1,C.

Step Four: The flap is pushed into the bowel lumen and held in place by a stitch in the middle goining through the unsutured edge of the gall bladder incision and the base of the flap. The above edge is then sutured by interrupted sutures to the base of the flap and the operation is completed by continuing the seroserous attachment suture, Fig. 1,D. Gross section, Fig. 1,E. The operation may be done with or without clamps.

EXPERIMENTAL WORK

Dog 4 No. 1946: Operated on December 21, 1945 with the technic described above. Excellent condition throughout. Autopsy, March 9, 1946. No adhesions in the upper abdomen. Liver appeared normal in size, color and consistency. Gall bladder normal in thickness of walls and color, mucosa smooth and normal. It contained no foreign substance. The flap shows no atrophy.

Dog 2, No. 1847: Operated on Decemeber 7, 1945, good condition. Autopsy, March 8, 1946. Findings as in first dog.

Dog 3, No. 1947: Operated on December 21, 1945. Condition and findings in the main as dogs above. Autopsy, June 26, 1946.

Dog 4, No. 1946: Operated on December 21, 1945. Autopsy, June 26, 1946. Condition and findings similar to dogs above.

Dog 5, No. 1945: Operated on December 21,

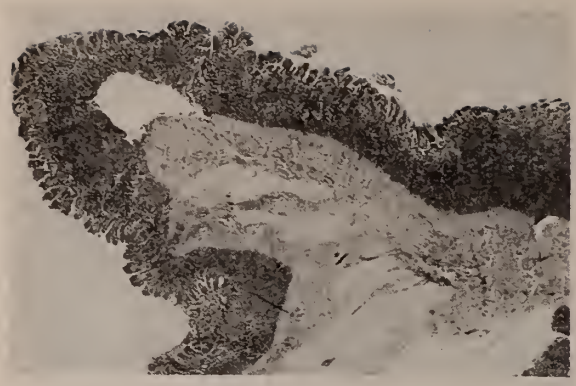


Figure 3

1945. Autopsy, June 26, 1946. Condition and findings duplicate those above.

The dogs as mentioned above made uneventfull recoveries and remained in excellent condition throughout. The gall bladders were all empty of foreign material testifying to the value of the flap. The gross specimen Fig. 2, A and B shows the flap closed and open with no flap-atrophy. It is to be noted that the flap is shown with the bowel markedly everted. *Particularly interesting were the microscopic findings. As the flap turned into the bowel presents a serous and mucous side we were curious to learn the fate of the serous coat in its new intra-intestinal environment. Fig. 3 shows that the alien serosa has been completely overpowered and replaced by the native mucous membrane which now covers the entire flap.*

We would have liked to keep some of the dogs at least one year but owing to the unusual amount of work ahead, the cases were needed. However, six months should be a sufficient length of time to demonstrate the feasibility of the operation.

I wish to express my gratitude for valuable assistance to Mr. A. L. Heese, Director of the Animal Hospital, and to Professor Otto F. Kampmeier, Head of the Department of Anatomy of the University of Illinois, for giving me the opportunity of carrying out this work.

2376 East 71st Street

Deep Mycotic Infections in Illinois

Esther Meyer, Ph.D., Chicago, and

Marvin S. Kagen, M.D., Appleton, Wis.

Deep mycotic infection are not rare in Illinois. We wish to report summaries of eleven cases which occurred recently, along with the relatively simple methods used in the laboratory diagnosis. These infections include one each of sporotrichosis and cryptococcosis, five of actinomycosis, two of North American blastomycosis and two of Madduromycosis.

Although reports in the literature on fatal deep mycotic infections are much less common than bacterial infections, yet in vital statistics of the United States for 1942, 359 deaths were reported.[1] The most common infection belonging to this group is Actinomycosis. This disease is common in cattle and was first recognized by Bollinger in 1877[2]. At his suggestion the causative agent was studied by Harz in 1878, a botanist, who described and named it *Actinomyces bovis* or ray fungus. Wolff and Israel[3] in 1891 isolated an actinomycetes by anaerobic culture from pathological material and established the fact that it would not grow aerobically.

In the same year, Bostroem in an effort to culture the organism from similar material used

From the University of Illinois, College of Medicine, Dept. of Bact. and Public Health, and the Hektoen Institute for Medical Research of the Cook County Hospital.

aerobic methods. He failed to isolate *Actinomyces bovis* but did isolate an aerobic actinomycetes occasionally present in actinomycotic lesions and which he erroneously named *Actinomyces bovis*. This led to considerable confusion, however, now it is generally believed that Bostroem's organism was a saprophytic soil contaminant and Topley and Wilson[4] suggest this organism be called *Actinomyces graminis*.

It is, however, agreed that there are pathogenic aerobic species of Actinomyces, now classified as Nocardia by Waksman and Henrici[5]. It is also suggested by Skinner, Emmons and Tsuchiya[1] that strictly speaking actinomycosis should refer only to the disease caused by the anaerobic strain, *Actinomyces bovis*, while the infection caused by the species of aerobic Nocardia be called Nocardiosis.

Actinomycosis in man occurs most often in the cervico-facial, abdominal, and pulmonary regions. Nocardiosis occurs in man in such conditions as Madura foot, pulmonary infection, meningitis and brain abscesses.

According to Kolouch and Peltier[6], in the years 1930-1936, the average number of reported deaths from Actinomycosis was just over 60 per year.

The first report on Sporotrichosis in this country was published by Schenck in 1898[7] and de Beurmann in 1912[8] reported cases which occurred in France. Since then there have been cases reported from many parts of the world. There is some evidence, however, that in certain geographical locations this disease occurs more frequently. There have been more than 200 cases of Sporotrichosis reported to date in the United States. According to Foerster[9] 130 out of 148 cases in this country have occurred in the Mississippi Valley. He also comments that 14 of his 18 cases resulted from wounds caused by barberry thorns.

Collins in 1947[10] reviewed the literature on disseminated sporotrichosis and cites 6 cases. He comments on the fact that American literature revealed few cases showing visceral involvement. He further reported one fatal case which came to his attention.

Busse in 1895[11] was the first to report the presence of an encapsulated yeast in pathological material. Benham[12] and Skinner, Emmons and Tsuchiya[1] called attention to the fact that cryptococcosis in the United States and in Europe was caused by the same encapsulated yeast but that in Europe the disease is usually of the generalized type showing skin lesions while in the United States, it is primarily an infection of the central nervous system. Further, that in many of the latter cases, lesions were found in the lungs at autopsy and they believed these to be the primary lesions.

Cox and Tolhurst[13] in 1946 reported their observations on 13 cases of cryptococcosis which came to their attention in Melbourne, Australia, and have included a complete review of the incidence throughout the world. They add that to date slightly more than 100 cases are recorded, most of which occurred in the United States.

Blastomycosis was first reported by Gilchrist[14] in 1896 but the organism was not cultured until 1898 by Gilchrist and Stokes[15]. They demonstrated that the fungus grew as a mold on artificial media and occurred in tissue as large, double-contoured round or oval yeasts.

Martin and Smith[16] in 1939 published a complete review on Blastomycosis and after a careful study of the literature expressed the opinion that there were 80 proved cases, 163 presumptive cases, and 104 inadequately described cases in the literature. While this mycotic infection has been reported from most areas in the United States, it is chiefly seen in the Middle West particularly around Chicago and is sometimes called "Chicago disease."

Maduromycosis is defined as a chronic infection usually of the foot, caused by a variety of fungi belonging to different genera and species[17]. Some confusion existed in the literature concerning the terms used to describe this condition according to the etiology. It was suggested in 1916 by Chalmers and Archibald[18] that the term Madurmycosis be used for the infections caused by molds having large hyphae; Mycetoma being used to include both Actinomycosis caused by Actinomyces and Nocardia both having delicate hyphae, and Maduromycosis.

This mycotic infection is characterized by the presence of granules in the tissue and sero-purulent discharges. These granules may be either white, yellow, red or black depending upon the fungus causing the infection.

Maduromycosis occurs most frequently in Southern India and other tropical countries but cases have been reported in Canada and in the

United States. According to Gammel[19] 24 cases have been found in this country up to 1927, 18 of which were caused by species of Actinomyces. Recent reports include those of Emmons[20], Fienberg[21], and Weidman and Kingman[22].

REPORT OF CASES

Case No. 1. Actinomycosis Infection of Lung. M.C., a 56 year old white male, who was employed as a painter entered the hospital on April 19, 1947, complaining of cough, shortness of breath, weakness and fatigue. Four weeks previously, there had been a gradual onset of cough and low grade fever. Examination upon admittance to the hospital revealed a temperature of 103 degrees F., carious teeth and dullness with loss of breath sounds over the left lower chest. Aspiration of the left lower chest revealed a foul smelling greenish purulent material.

A smear of the pus revealed delicate branching filaments, and a pure culture of *Actinomyces bovis* was isolated. The empyema of the left chest was opened and drained with a thoracotomy. One hundred thousand units of penicillin every three hours, and sulfadiazine one gram every four hours, were administered for thirty-five days. One week after the thoracotomy, potassium iodide in a gradually increasing dose up to 150 grains daily was given. The patient made an uneventful recovery.

Case No. 2. Actinomycosis of Chest and Abdomen. L. C., a 34 year old white male, developed fever associated with pain over the left side of the chest in March 1945. In July, 1945, a thoracotomy was performed and yellow purulent material was recovered.

Another thoracotomy was performed in December, 1945. In February, 1946, a perinephritic abscess developed and was drained. X-ray examination at this time revealed a left pleural effusion. The patient received penicillin and sulfathiazole, both of which failed to effect the downhill course. In June 1946, a firm irregular mass was found in the right lower quadrant of the abdomen. A laparotomy was performed and many granulomatous masses were found in the peritoneal cavity. This wound developed into a draining sinus.

On October 29, 1946, *Actinomyces bovis* was isolated from the draining sinus of the chest. Two hundred thousand units of penicillin were given every three hours, along with sulfadiazine. The patient also received deep x-ray therapy and supportive measures including blood transfusions. Although the patient weighed less than 100 pounds upon entering the hospital, he gained 40 pounds during the three months stay, and has continued to improve since he left.

Case No. 3. Actinomycosis of the Breast. In September, 1946, R. E., a 28 year old white female entered the hospital complaining of generalized aches and pains associated with profuse sweating for the past six weeks. One week after the onset of the aches and pains, she noticed pain and swelling in the right breast. Physical examination revealed an egg sized mass with tenderness in the right breast, and redness of the overlying skin. The cellulitis subsided in one month after the administration of oral sulfadiazine, and the abscess which formed was incised and drained.

Yellowish purulent material continued to drain from the wound for eight months, at which time a culture revealed *Actinomyces bovis.*

Case No. 4. Actinomycosis of the Jaw. M. G., a 30 year old negress entered the outpatient clinic complaining of a draining sinus over the left upper jaw and a plum sized firm indurated mass at the angle of the left lower jaw. An infection of the root of the second upper molar was found, and the root was removed. Within one week, the sinus had healed.

The plum sized mass, which had been present for about three months, was incised and a whitish caseous material was found within. A few drops of yellowish purulent material revealed branching filaments in gram stains, and the culture was identified as *Actinomyces bovis.*

The upper draining sinus was due to an infection of a tooth root. Unfortunately, the patient has not returned for further examination and treatment.

Case No. 5. Actinomycosis of the Abdomen. E. S., a 31 year old white female, had an appendectomy in March, 1946, and within two months developed a stitch abscess, rectal abscess, and subphrenic abscess. The subphrenic abscess was opened and drained retroperitoneally and was still draining when the patient entered the hospital in February, 1947.

The patient complained of pain over the right lower quadrant of the abdomen, radiating to the right inguinal area. The pain was severe and dull in nature, being aggravated by motion. Pain was also present over the right hip and radiated down the right leg. Anorexia, nausea, and occasional vomiting were present. Low grade fever was present until the patient was placed on sulfadiazine, one gram four times a day.

Actinomyces bovis was isolated from the purulent material of the subphrenic abscess. The wounds healed in six months and the symptoms gradually disappeared. The sulfadiazine was continued for eight months.

Case No. 6. Disseminated Subcutaneous Sporotrichosis. J. S., a 69 year old white male entered the hospital on January 2, 1947, complaining of pounding in the head for the past six weeks, and nodules beneath the skin for a ten day period.

The erythematous, acorn sized, subcutaneous nodules were painless having appeared gradually on the face, mainly on the extensor surfaces of the extremities, and a few on the body. Subcutaneous nodules were also palpated along the lymphatic vessels of the arms and thighs. New nodules appeared during the first week in the hospital, after which no new lesions occurred. Many of the nodules developed into abscesses and cultures prepared from a few drops of the yellowish pus revealed *Sporotrichum schenckii.*

The patient left the hospital and returned one month later complaining of weakness and a ten pound loss in weight. Potassium Iodide was administered gradually increasing the dose to 50 grains three times a day. Within one month, all of the lesions healed and the patient was discharged. No history of contact with

plants could be obtained, and the patient had been unemployed.

Case No. 7. Pulmonary Cryptococcosis (European Blastomycosis). D. T., a 6 year old white boy from Decatur, Illinois, developed a whistling noise in the chest associated with respirations in October, 1945. The patient had a productive cough associated with frequent attacks of dyspnea and cyanosis. A right atelectasis was present, and the right bronchus was found to be excluded by a soft polypoid-like tumor. Cultures prepared from the sputum and biopsy material revealed *Cryptococcus neoformans,* although skin tests with an antigen prepared from this organism had previously been negative. Histo-pathological sections revealed the typical encapsulated yeast cells.

In the lungs, there was evidence of chronic fibrotic changes on the right side with markedly expanding cystic areas in the right infra-clavicular region. Laminagraphic films demonstrated a tumor mass arising in the right wall of the distal portion of the trachea, and extending into the main right bronchus. The mass was removed by bronchoscopic approach. The patient received two million units of penicillin while in the hospital, and has been free of symptoms for over one year.

Case No. 8. Systemic North American Blastomycosis. W. I., a 50 year old, white sheet metal worker, developed pain over the right side of the chest about two years ago. There was a gradual onset of blood tinged sputum, shortness of breath, 15 pound loss in weight, and coughing. The pain was sharp in nature, being aggravated by coughing or taking a deep breath.

Examination revealed a low grade fever, 23 respirations per minute, impaired resonance over the lower part of the upper lobe of the right chest anteriorly, and the upper part of the lower lobe posteriorly. Three weeks after admission to the hospital, the patient developed a granulomatous lesion on the face and left thigh. He was slightly sensitive to Blastomycin. All lesions responded to potassium iodide therapy. The patient was discharged from the hospital on May 12, 1944, and was well until he developed dysuria in February, 1945, at which time blastomycosis of the prostate gland was found. The infection responded to potassium iodide and deep X-ray therapy.

On March 8, 1946, a right epididymidectomy was performed because of a persistent infection of blastomycosis. The organism identified as *Blastomyces dermatitidis* was cultured from the sputum, skin lesions, prostatic fluid, and epididymis. Since the last operation, the patient has returned to work and no longer has any symptoms.

Case No. 9. Systemic North American Blastomycosis. S. W., a 39 year old negro woman, precipitously delivered a full-term baby on the street, on December 24, 1946. Several days later, she noticed several subcutaneous nodules on the right forearm. During the next two months, dozens of golf ball to hen egg-sized abscesses appeared over the entire body. Many of them opened spontaneously, and formed verrucous lesions with light yellow purulent drainage. Upon entering the hospital, she had a low grade fever, 20 pound loss in weight, weakness, headache, and malaise. She had nursed her baby, who has remained healthy. She had not been out of Chicago during the past two years, and had no contact with flowers, gardening, or animals.

The patient was sensitive to Blastomycin and was desensitized. She was then placed on gradually increasing doses of potassium iodide. Bilateral infiltrations were present in the lungs, a wrist joint became involved, and a stiff neck developed about one month before the patient died. The entire course of the disease lasted about six months. *Blastomyces dermatitidis* was cultured from the abscesses, but was not recovered from the milk of the mother.

Case No. 10. Maduromycosis. Q. F., a 23 year old colored female employed as a sewing machine operator, developed an indurated pea sized area on the right foot. The lesion was tender and had a brownish color. The lesion gradually enlarged until it was one and one-half centimeters in size and had become more painful.

Seven weeks after the lesion had appeared, it ruptured spontaneously while walking. The lesion had become 2 cm. in diameter, had a brownish color, and serous bloody material drained from a central sinus. The entire lesion was excised surgically, and healed by primary intention. Black sulfur granules were found in the histopathological sections and a diagnosis of maduromycosis was made. Unfortunately, no material was available for culture.

The wound has remained healed for five months and there has been no evidence of a recurrence.

Case No. 11. Maduromycosis. W. M., a 32 year old colored male, born in Tennessee, had lived in Chicago for the past two years. Two years before entering the hospital, he noticed swelling of the right foot, followed by dull pain after exercise. The swelling and pain of the right foot would disappear when the involved leg was elevated.

Almost 18 months after the onset of swelling, small nodules appeared over the sole and instep, which broke down and developed into draining sinuses. Yellowish serous material would drain from the sinuses. Upon entering the hospital, about one hundred sinuses were present, and the right foot was about twice as large as the normal left foot.

X-ray films of the involved foot revealed multiple punched out areas of the bones with little evidence of periosteal proliferation. The C. B. C. and urine were negative, and the Kahn was negative. An aerobic actinomyces was cultured and identified as *Nocardia asteroides.*

LABORATORY DIAGNOSIS

Cases Nos. 1, 2, 3, 4, *and* 5. Actinomycosis.

Actinomycosis may be caused by aerobic or anaerobic strains of Actinomyces therefore both methods of culture were used. The following procedures were carried out:

1. *Macroscopic examination* — Each specimen was examined for sulfur granules by spreading the material over a small area in a sterile petri dish. They were sufficiently large to be apparent macroscopically in only one specimen.

2. *Microscopic examination* — A generous sample of the pus was placed in a drop of 20 per cent potassium hydroxide and a cover slip added. Using the low power of the microscope, a search was made for sulfur granules. They were found in all specimens and consisted of tangled masses of delicate mycelium, 1 micron in diameter. In only one, were clubs seen at the periphery of the granules.

3. *Gram Stains* — Gram stains of the pus revealed branching filaments, irregularly gram positive together with rod shaped fragments having the appearance of diphtheroids.

4. *Cultures* — Duplicate cultures were inoculated as follows providing sufficient material was available: Brewer's thioglycollate semi-fluid medium containing dextrose and petri plates of Brewer's agar, brain-heart infusion agar, chocolate agar, beef extract blood agar and beef extract agar. In cases where a small sample was sent to the laboratory, the medium of choice was Brewer's thioglycollate semi-fluid medium. The latter cultures were incubated aerobically at 37° C. One set of plates was incubated anaerobically, the other aerobically both at 37° C. The aerobic plates were examined daily for growth while the anaerobic jars were opened after 7 to 10 days.

All of the actinomyces in this series grew under anaerobic conditions only, which is characteristic of *Actinomyces bovis.* This organism is fastidious in its nutritional requirements and frequently unpredictable as to the type of media on which it will grow. Brewer's semi-fluid medium proved to be the one single medium on which all strains grew well producing granular growth. One culture grew on this medium only. Even in the presence of bacterial contamination, one could identify the granular growth characteristic of Actinomyces. Chocolate and brain-heart infusion agars were next best for the cultivation of these organisms and in that order. Only one strain grew on beef extract agar. Gram stains prepared from colonies and growth in Brewer's semi-fluid medium showed typical actinomyces morphology.

The colonies were of the smooth and rough types. The former were opaque, white, or with a slight yellow tinge and a glistening surface. The rough types were wrinkled with a pitted surface and irregular margins.

Attempts to infect laboratory animals have not been successful with *Actinomyces bovis* and therefore animal pathogenicity tests were not performed. Biochemical reactions have no differential significance and were not carried out.

Case No. 6. Disseminated Subcutaneous Sporotrichosis.

A gram stain was prepared from the freshly aspirated pus obtained from a furuncle-like lesion on the skin. In these smears the parasitic form could not be found, which is generally the case in human infections caused by *Sporotrichum schenckii.* Mycological diagnosis is dependent chiefly on cultural studies.

The purulent material was streaked on Sabouraud's dextrose agar slants and incubated at room temperature. Growth was apparent in five days and appeared first as moist, shiny, tan colored colonies with a fine mycelial fringe adherent to the agar medium. As the culture aged, the color deepened to a dark brown and eventually became quite black. Later, the growth developed a leathery consistency and became more and more wrinkled.

Slide mounts prepared from the primary growth showed the typical structure of Sporotrichum, namely, delicate mycelia about 2 microns in width, short stalks (conidiophores) attached to the mycelia and clusters of pear shaped spores borne from the end of these lateral branches. Some conidia were also attached directly to the undifferentiated hyphae.

A male rat, the most susceptible laboratory animal, was inoculated intraperitoneally with a saline suspension of the culture. The animal developed orchitis characteristic of this infection. After 3 weeks, the rat was sacrificed and bits of tissue from the testes, liver and spleen were transferred to Sabouraud's agar. After five days, growth was apparent and proved to be typical of the Sporotrichum injected. The organism was identified as *Sporotrichum schenckii.*

Case No. 7 — Pulmonary Cryptococcosis (European Blastomycosis).

Sputum and later a bronchoscopic specimen were mounted in 20 per cent potassium hydroxide solution and examined for fungi. Small, round, budding yeast cells surrounded by a moderate sized capsule were seen in these mounts. This morphology would indicate a possible cryptococcosis. Accordingly, material was transferred to Sabouraud's dextrose agar and incubated at room temperature. Typical yellowish white, opaque yeast-like growth was apparent in 4 days. Microscopic mounts consisted chiefly of round budding yeast cells having considerable variation in diameter (2 to 15 microns). Capsules could not be demonstrated in these cultures even though the material was mounted in India ink. The culture has been transferred several times since its isolation but has never developed the moist, slimy mucoid character.

A mouse was injected with 0.5 cc. of a saline suspension of the culture. The animal was sacrificed at the end of one month and typical gelatinous masses were present in the mesentery, lungs, liver, spleen and brain. Mounts prepared from the lesions showed large, encapsulated yeasts and typical growth occurred on Sabouraud's dextrose agar.

This organism produced a very slight amount of acid but no gas in dextrose, maltose, sucrose and lactose but biochemical reactions are neither uniform nor diagnostic. The organism was identified as *Cryptococcus neoformans.*

Case No. 8. Systemic North American Blastomycosis.

Samples of sputum, bits of tissue, pus from skin lesions, and prostatic fluid were each placed in a drop of 20% solution of potassium hydroxide and allowed to clear by standing at room temperature for 15 to 20 minutes. In these specimens, the organism causing this disease appeared as round, double contoured (thick walled) budding yeast cells, 8 to 20 microns in diameter. The light was reduced when examining these unstained specimens.

Samples of each were cultured on Sabouraud's dextrose agar slants at room temperature and blood extract agar plates at 37° C. The blood agar plates were sealed with adhesive tape to prevent drying during the long incubation period.

Typical wrinkled, waxy colonies, yellowish in color and not unlike the growth of Mycobacterium tuberculosis appeared on the blood agar plates in 5 to 7 days. Microscopic examination of the growth revealed budding yeast cells along with occasional short mycelial fragments.

On Sabouraud's dextrose agar slants incubated at room temperature, the growth developed as a white, cottony mycelial mold later becoming tan to brown. Mounts were made by placing a bit of the fungus in a small drop of lacto phenol cotton blue and teasing it apart gently. A coverslip was pressed down carefully over the teased specimen. This culture showed septate mycelium and numerous round to pyriform conidia 4 to 6 microns in diameter. This mycelial culture could readily be converted to the yeast phase by subculturing it on blood agar and incubating at 37° C. This procedure is usually done to verify the identity of the fungus for the culture can with regularity be converted from one form to the other by using the proper medium and temperature of incubation.

Mice are the most susceptible of the laboratory animals. It is not necessary to use an animal in the identification of this culture, however, 0.5 cc. of a saline suspension of the blood agar culture was injected intraperitoneally into mice. One was sacrificed at the end of 3 weeks and the other died at the end of 4 weeks. Both animals showed caseous nodules on the peritoneal surface as well as in the liver, spleen, lungs and lymph nodes. Typical yeast cells could be demonstrated by mounting a bit of any one of these tissues in a small amount of 20 per cent potassium hydroxide solution. The organism was identified as *Blastomyces dermatitidis*.

Case No. 9. Systemic North American Blastomycosis.

Exactly the same procedure was used as outlined above. With this specimen, however, growth occurred only on blood agar medium in the primary isolation. Later it was adapted to grow on Sabouraud's dextrose agar. The culture was identified as *Blastomyces dermatitidis*.

Case No. 10. Maduromycosis.

Cultures could not be made because the tissue had accidentally been fixed in formalin. Black sulfur granules 1-4 mm. in diameter were clearly apparent in the tissue and some had fallen to the bottom of the specimen bottle.

Microscopically the granules were composed of a mass of branched hyphae containing large chlamydospores and hyphal swellings. At the periphery the hyphae showed terminal chlamydospores. This type of granule is found as a rule in infections caused by higher mold-like fungi but the infection cannot be classified according to color of the granule. Occasionally an associated micrococcus imparts the black pigment.

Case No. 11. Maduromycosis.

A swab only was brought to the laboratory. A small amount of the material was mounted in 20 per cent potassium hydroxide but no granules were found.

The rest of the material was transferred to Sabouraud's dextrose agar and infusion agar and incubated aerobically at 37° C. The culture developed as a glaborous, waxy, wrinkled, elevated colony and on aging became orange colored. Gram stains showed gram positive, delicate, branching hyphae along with diphtheroidal and coccoidal fragments. It was slightly acid-fast. The culture was pathogenic for guinea pigs. The organism was identified as *Nocardia asteroides*.

DISCUSSION

Actinomycosis of the cervico-facial, thorax, and abdominal regions is not rare and the organism can be isolated by relatively simple procedures. Sulfadiazine given in doses of 1 gram 4 times a day appears to be extremely useful in the treatment. In one case of actinomycosis of the chest and abdomen, penicillin had previously been given in small doses along with sulfathiazole. When this same patient received 200,000 units of penicillin every 3 hours and sulfadiazine, he immediately began to improve.

The sensitivity of the individual strain plays a large role in determining which drug will be most effective, however, in this case it appeared that the higher blood level of penicillin was far more effective. In addition. potassium iodide given orally is indicated after adequate surgical drainage is established.

Filtered x-ray given in doses of 150 r every other day until 1500 to 2200 r has been given is recommended by Lamb, Lain, and Jones, for the cervico-facial type of actinomycosis[23]. In extremely resistant cases, desensitization with a specific vaccine may be employed.[24] All cases should be followed over a period of several months or years before one can be sure a cure has been effected.

The localized, lymphatic type of sporotrichosis has become rather uncommon in the middle west. In this paper, we have described a case of disseminated subcutaneous sporotrichosis. This condition usually responds to gradually increasing doses of potassium iodide given orally.

Cryptococcosis caused by *Cryptococcus neoformans* is believed to enter the body via the respiratory tract and may effect the bronchus, lung, meninges, or become generalized. Isolated lesions have been reported on the skin, subcuta-

neous tissue, lymph nodes, tongue, knee, or muscles. The latter may spread to involve the meninges, which usually proves fatal.

The pulmonary polypoid-like tumor due to *Cryptococcus neoformans* which occurred in a 6 year old boy responded to penicillin and surgical excision. It is difficult to evaluate the role of penicillin in this case, however, it is worthy of further trial in cryptococcosis since it has proved to be effective in vitro.[17]

Blastomycosis may evidence itself as a cutaneous or systemic disease in humans. The cutaneous variety usually responds rapidly to potassium iodide given orally and is rarely fatal. The systemic variety which generally begins in the lungs and then spreads via the blood stream is usually fatal within a few months. One of our patients is apparently well following potassium iodide therapy, deep x-ray therapy and a right epididymidectomy. This, however, is the exception and not the rule and only allows us to conclude that the disease is not always rapidly fatal. Our second case of blastomycosis, which proved fatal, did not transmit the disease to her nursing infant, members of her family, or patients in the same ward although she had numerous open lesions.

Maduromycosis is a chronic infection generally effecting the feet characterized by the development of tumefactions and sinuses and being due to a variety of fungi. One of the cases was an early infection and the other was far advanced. The early case had black sulfur granules and was apparently cleared up by surgical excision. It will need to be followed, of course, for a considerable length of time. The best results can be obtained by early diagnosis and surgical excision of the involved area.

SUMMARY

Five cases of actinomycosis have been presented: one involved the lung with empyema; the second the chest and abdomen; the third a breast; the fourth the cervico-facial area, and a fifth the ileocaecal region of the abdomen with a complicating subphrenic abscess.

In all of the above cases the anaerobic strain, *Actinomyces bovis* was isolated in pure culture. Brewer's thioglycollate semi-fluid medium containing dextrose was the most useful for the primary cultivation of this organism.

In the treatment of actinomycosis surgical drainage, penicillin, sulfadiazine and potassium iodide were used with good results.

A patient suffering from disseminated subcutaneous sporotrichosis responded favorably to potassium iodide therapy. *Sporotrichum schenckii* was cultured on Sabouraud's dextrose agar from the purulent material of a superficial abscess.

A case of pulmonary cryptococcosis involving the bronchus was successfully treated with bronchoscopic surgery and penicillin *Cryptococcus neoformans* was isolated on Sabouraud's dextrose agar.

Blastomyces dermatitidis was cultured on blood agar and Sabouraud's dextrose agar from the sputum, skin, prostatic fluid and epididymis of a patient with systemic blastomycosis. The patient responded to potassium iodide therapy, deep x-ray therapy, and a right epididymidectomy. He has remained well for 8 months.

Another patient with systemic blastomycosis died from the disease within six months. *Blastomyces dermatitidis* was cultured from pus obtained from several of the lesions.

Two cases of maduromycosis are reported. *Nocardia asteroides* was cultured from one patient.

Deep mycotic infections are not rare and should be kept in mind when dealing with a chronic infectious disease.

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Unnecessary Rectal Operations Done In The Presence Of Cancer Of The Large Bowel

Raymond W. McNealy, M.D., and Durand Smith, M.D.
Chicago

This paper is the result of a study made at Wesley Memorial Hospital. The stimulus for the analysis was the repeated history of rectal operations having been performed in the presence of undiscovered malignancy of the bowel. In order to obtain an accurate picture of the frequency of this regrettable error, we reviewed the records of all patients entering the hospital for the period from July 1943 to January 1947 with a diagnosis of carcinoma of the lower gastrointestinal tract. We restricted the survey to individuals in whom a tumor mass could be felt by digital examination of the rectum. The reason for limiting this series to subjects in whom the correct diagnosis could have been made by proper digital examination was to preclude the common excuse that a lack of diagnostic instruments was responsible for the failure to discover the malignant lesion. We considered as pertinent only that treatment which had been rendered immediately preceding admission to the hospital.

In making our study, we reviewed 95 cases of large bowel malignancy. Of this number, 56 came within the limitations mentioned above — i.e. carcinoma which could be felt by digital examination. Yet 42.8% of this group were treated for bowel conditions other than carcinoma. The treatment given proved very interesting. Fifty per cent were managed surgically, the other half medically. The surgical regime is even more enlightening. Of the entire series, 17.85% had actual operative intervention in and about the rectum; 10.7% had hemorrhoidectomies, 5% had anal fistulectomies. Moreover, 3.57% had hemorrhoids injected with sclerosing material. One person had two hemorrhoidectomies. Many who were under medical care were given suppositories. In others, attention was directed towards the bleeding, diarrhea and spastic colon.

Carcinoma of the rectum does not present the same picture in every patient. For this reason, one must be alerted constantly to the possibility of a malignant lesion by any one or several of a group of signs and symptoms whioh occur with large bowel pathology. Bleeding from the rectum is by far the most common complaint. Bloody stools was noticed by 78.5%. In the majority of cases the blood was dicovered at the time of bowel movement. Others passed blood or bloody mucus. A change in bowel habit was described

Presented before the 108th Annual meeting, Illinois State Medical Society, May 10-12, 1948.
From the Dept. of Surgery — Wesley Memorial Hospital, Chicago.

DATA

Number of cases	56
Average age	57.8 yrs.
Sex Males	57.1%
Females	42.9%
Subjected to surgery	21.4%
Treated medically	21.4%
Total treated	42.8%
Average distance of tumor above anal verge	6.5cm (2.56 in)
Average greatest diameter of tumor	5.53cm (2.17 in)
Duration of symptoms in untreated patients	7.5 mo.
Duration of symptoms in treated patients	9.0 mo.

Symptoms	Frequency		Duration in months
Bleeding (rectal)	78.5%		8.26
Change in bowel habit	65.9%		
Diarrhea	32.1%		4.77
Constipation	26.7%		10.6
Alt. diarrhea and constipation	7.1%		6.5
Weight loss	26.7%	(19.6lbs)	5.64
Pain in rectum	12.5%		8.4
Pain with B.M.	8.9%		8.1
Decrease in calibre of stool	8.9%		8.0
Weakness	8.9%		8.0
Urgency	7.1%		2.66
Mucus in stool	3.5%		6.2
Tenesmus	3.5%		

in 65.9%; either as diarrhea — 32.1%, constipation — 26.7%, or alternating diarrhea and constipation — 7.1%. It is of little value to elaborate on the symptoms and their diagnostic importance. From our study it is evident that one should be exceedingly cautious in attributing findings in any individual case to a single cause until a thorough examination excludes other lesions, particularly carcinoma. In this series 42.8% were treated for one condition when actually two possible sources of the symptoms were present. Many were treated for hemorrhoids, yet all had concomitant malignancies. Hemorrhoidal tissue is found in varying amounts in the routine examination of most adults beyond the age of fifty. Hence the finding of hemorrhoids in the presence of bleeding or any other rectal complaint does not preclude the presence of other pathologic conditions. A history of bleeding should definitely encourage one to investigate completely the status of the entire large bowel. Approximately 75% of all rectal cancers can be felt with the index finger. In this series 100% could have been diagnosed correctly and earlier, had the initial examiner been thorough. As a result of the failure to recognize the lesion early, there was a definite avoidable delay in the treatment of the malignancy. This is predicated on the assumption that the symptoms, of which the patient complained at the time that the correct diagnosis was made, were the continuation of the symptoms which he had earlier. We are also assuming that the symptoms, both early and late, were attributable to the malignant lesion. The average duration of symptoms in untreated patients was 7.5 months, while the average duration of symptoms in patients who had some type of rectal treatment not directed to the malignant lesion was nine months.

It is a concept of law that all men are considered innocent until proved guilty. In large bowel studies the converse should be true — that all symptoms are the result of a malignancy until proved otherwise.

CONCLUSIONS

1. All rectal symptoms demand a thorough and complete study.

2. Coexisting rectal lesions are present in many patients with carcinoma of the rectum.

3. Hemorrhoidectomy or other rectal surgery should not be performed until the presence of carcinoma is definitely ruled out.

SUMMARY

1. In a series of 56 cases in which the carcinomatous lesion could be felt with the index finger, 42.8% were subjected to unnecessary treatment.

2. A correct diagnosis was not made early because malignancy was not suspected.

The Direct and Indirect Therapy of Acute Respiratory Infections

Ben E. Goodrich, M.D.
Detroit

The majority of acute respiratory infections are non-specific illnesses, the organisms are of multiple types and the illness is not infrequently associated with conditions which themselves require consideration. General health, errors in living or working conditions are of prophylactic importance together with dental infection and nasal and paranasal abnormalities.

In treatment of mixed respiratory infections, penicillin has the greatest usefulness and the least hazard. The pneumonoccus is particularly susceptible. The action of penicillin is not inhibited by pus as is the case with sulfonamides. Gram negative organisms acquire resistance to penicillin. It has recently been established that acquired resistance may be lost if resistant strains are grown in mixed culture with other organisms.[1] Occasional patients are sensitive to penicillin. The reactions are usually not serious. Patient sensitivity to oral penicillin does not infer that sensitivity to injected or inhaled penicillin is also present.

Streptomycin is hazardous. If given in sizable doses for longer than 10-14 days, increasing numbers of toxic results will occur. Vestibular and auditory nerve injury may be severe and improve slowly or not at all. Kidney injury has caused death. Contact reactions are frequent in both patient and professional attendant. Streptomycin can be given with penicillin both by injection or inhalation.

It has been recommended that sulfonamides be used routinely in pneumococcus pneumonia. Sulfonamides should be combined with penicillin in the treatment of streptococcal and staphylococcal infections. Combining two sulfonamides allows somewhat smaller dosage, and even though not of lesser amount may decrease possible toxic effects. Patients may be sensitive to the drugs. Calculi may occur in acid urine. Numerous strains of organisms have become resistant to the drugs.

Presented at the McLean County Medical Society, Bloomington, Illinois, March 9, 1948.

The therapy of acute respiratory infections is also dependent on an estimate or knowledge of the location of the inflammation and the condition of the patient. Age, debility, previous pulmonary disease, toxicity and complicating or coincident disease are individual variables. These features warrant a review of pulmonary function.

The purpose of respiration is gaseous exchange. This requires open airways, adequate motility, and a respiratory surface free from exudate. Surface cleansing of the tracheo-bronchial tree is chiefly mechanical. Ciliary action and mucous production are adjuncts to the vital mechanisms of bronchial peristalsis and cough. Intense inspiratory efforts do not collapse the semi-rigid major airways in the adult. Excess bronchial peristalsis may be disadvantageous to expectoration by too great a narrowing of smaller bronchi in expiration. A foreign body or a mucous plug drawn deeply into a dilated tube in inspiration may be firmly held during expiratory narrowing. A fixed partial obstruction allows entrance of air during inspiration but not its exit during expiratory narrowing. Thus bronchial malignancy leads first to localized emphysema. Atelectasis follows complete obstruction. Infection may occur at any stage of the disease process.

A second necessity in the preservation of gaseous exchange is clearing of the alveoli. A normal pulmonary segment can absorb quantities of liquid if the constituents are of simple molecular structure. An x-ray taken soon after near drowning may reveal a widespread consolidation which will be gone in a few hours. Drinker and Hardenbergh have demonstrated that fluid containing material of complex molecular structure is absorbed very slowly[3]. The process of protein digestion and molecular degradation allows delayed absorption to occur. Re-absorption of both simple and complex molecules is enhanced by positive pressure respiration. Expiratory bronchospasm is a natural protective reflex in the prevention of pulmonary edema and should not be

interfered with lightly. Contrary to popular opinion, Drinker states that the terminal lymphatic drainage is through a narrow channel at the apex of the right lung into the right subclavian vein[4]. This natural bottleneck is of a degree that the lung is structurally suited to edema at all times. This impending condition is aggravated by intense inspiratory effort or the absence of expiratory bronchospasm. It may be initiated by anoxia of alveolar epithelium.

The interstitial tissue is functionally a supportive framework. Elasticity is a necessity for normal function. Infection, inflammation and edema diminish elasticity. Infection advances most rapidly in the edema zone. Barry Wood has shown that phagocytosis of pneumococci can and does occur in pulmonary tissue before antibodies are present[5]. Such phagocytosis is mechanical and depends on the capture of an organism in tissue meshes with the phagocyte able to get a toe-hold, so to speak, and engulf an organism unable to float readily away. Measures decreasing interstitial edema increase phagocytosis, preserve elasticity and bronchial motility, and diminish alveolar exudate.

It is evident that desirable functions may be antagonistic. Alveolar exudation is controlled by bronchospasm which in excess traps secretions in the bronchi during expiration. The clearing of alveolar exudation is not aided by ciliary action, mucous production or cough. If exudation increases and ascends to the level of the bronchial cough reflex, aeration of the segment is interfered with. One is tempted to disregard these factors, treat the etiological agent, if known, and to hope for the best. It is not only interesting but helpful to utilize therapy related to function as well as therapy directed against infection. Such supplemental therapy must be suited to the individual patient and the variable abnormalities present.

SUPPLEMENTAL THERAPY

Antibodies: such as in sera, are chiefly useful against specific organisms. Such antibodies as are furnished incidentally by whole blood, plasma or fractionated plasma have not been greatly useful in adults. If the patient has anemia or low blood proteins these substances have values in addition to possible antibodies. If the patient is already threatened by an elevated venous pressure, the intravenous administration of further fluids may be undesirable.

Gases: Oxygen has a drying effect. In the adult this effect may be harmles although irritant to bronchial mucosa. The increased stickiness leads to adherence of mucous plaques which in the narrow trachea of a child may hasten obstruction and death. Oxygen does not increase bronchial peristalsis or depth of resperation.

Carbon dioxide increases bronchial secretions, peristalsis and depth of breathing all of which are aids in cleansing.

Steam lessens adherence of bronchial and tracheal discharges. In the child the addition of moisture should always be considered when oxygen is to be used. In bronchial disease steam is comforting to both child and adult.

Helium moves more readily in narrowed bronchi and allows greater gaseous exchange in diffuse variable obstructions.

Cough remedies may be used judiciously. Expectorants have a place in the therapy of the simple or complicated bronchial syndrome, as described by Soulas in the Presse Medical[6]. He reports that whether the inflammation is superficial or deep, there is lessening of secretions and motility. The expectorant action of ammonium chloride may be variable but it also increases depth of breathing and stimulates cardiac and renal function.

Excessive bronchial secretions together with excess bronchospasm warrants the use of antiexpectorants such as atropine. Also this medication diminishes vagus (para-sympathetic) action and thus lessens bronchospasm. An effect on bronchospasm of similar nature is produced by sympathetic stimulants (such as ephedrine).

Sedatives (codeine, hycodan, dolophine, morphine) require judicious use with consideration to periods of rest as well as to the local respiratory functional state.

Detergents (wetting agents) are reported by Bryson and Grace as being of value in threatened or actual tissue destruction[7]. They have not proved to be harmful. Their chief use is to augment the local action of instilled or inhaled antibiotics. In peribronchiectatic pneumonitis, early lung abscess or when purulent discharges, epithelial desquamation and bronchiolar necrosis is present the use of detergents is recommended.

In older patients vascular and metabolic abnormalities complicate infection. Uremic and diabetic patients have poor resistance to infections in general, but specifically suffer exhalant lung

injury and increased exudation. Pulmonary edema may also occur from inhalant injury, from left ventricular failure, from the right ventricular preponderance of mitral stenosis and also by fluids administered intravenously.

Direct or etiological therapy relates to the inhibition of the organisms present. Indirect or supplemental treatment relates to the patient, his age, toxicity, location of the infection, condition of the respiratory apparatus and associated or complicating conditions.

ACUTE TRACHEOBRONCHITIS

Acute tracheobronchitis is a good example of these variabilities. In adults the patient may feel relatively well and have slight fever and yet suffer marked substernal soreness and have a harsh tearing cough productive of thick purulent sputum. Extension is infrequent but the discomfort warrants attention. Direct therapy by penicillin aerosol is very promptly comforting as compared to that produced by injection of penicillin or resultant from sulfonamides. When the bronchial factor is considerable, steam, ammonium chloride, and carbon dioxide inhalations may be used. If oxygen is used as the nebulizing force for the penicillin, carbogen (5-10% CO_2 and oxygen) has the added advantages of increased depth of respiration, and an augmentation of the cleansing bronchial physiology of liquefaction, ciliary action, and peristalsis.

In childhood this illness may rapidly become an acute emergency. Toxicity is progressive, extension is frequent and tracheal obstruction occurs unexpectedly soon. Inhalation therapy is difficult in children and cannot be depended on. The infection is often mixed and penicillin, sulfonamides and streptomycin can be given concurrently. In children, humidification of the respiratory atmosphere is vital. Oxygen without moisture may hasten the onset of asphyxia. In children when toxicity, wheezing and cyanosis appear, arrangements for complete therapy, including tracheotomy must be promptly made. This is a condition where sedation and sedative cough remedies such as morphine should not be used.

ACUTE BRONCHITIS

This illness varies greatly dependent on localization. A large tube bronchitis may show moderate toxicity, have a productive cough and reveal numerous coarse, moist, and sonorous rales. It is almost always bilateral. The condition is evident on examination and the X-ray film is clear. There is the hazard of recurrent infections and thus it is particularly disadvantageous to patients with bronchial asthma or pulmonary emphysema. The progressive development of bacterial allergy is a great probability. These minor infections warrant treatment. Inhalation is an excellent method.

A fine tube bronchitis results in greater toxicity but less cough and sputum and few physical findings. The fewer the symptons and findings the greater the threat. Epithelial desquamation, obstruction, atelectasis, bronchopneumonia and tissue destruction follow anadequate treatment. Fifty per cent of patients having bronchiectasis date their cough to a specific illness. Fine tube bronchitis (bronchiolitis, terminal bronchitis) warrants both inhalation and injection treatment. Aerosol mist will reach the area but injected medication will also be useful. Adjuncts may be advisable since the localization is beyond the point of the bronchial cleansing mechanism of cough, ciliary action and peristalsis. Retarded clearing warrants sputum investigation for resistant gram negative organisms. The condition demands treatment prolonged until clearing occurs which may be weeks or even months. Age and debility are important factors in this regard.

ACUTE PNEUMOCOCCIC PNEUMONIA

This disease with its characteristic onset is usually diagnosed promptly and accurately without technical assistance. Listen to the story, look at the patient and the sputum, and count the respiratory rate. An abrupt onset, with a single chill occurring in a person who rapidly becomes toxic and coughs rusty sputum and has an increased respiratory rate is typical of the disease. If possible, a white blood count will help greatly inprognosis, a low count being of great seriousness. If sputum examination can be done, an unexpected organism also may alter treatment. The pneumonococcus is very sensitive to penicillin and since "sulfa" resistant strains are not infrequent, the treatment of choice is penicillin. If there is no response in 48 hours, the presumptive diagnosis of pneumococcal lobar pneumonia is likely incorrect.

Secondary empyema may be readily sterilized by adequate early therapy. In some instances, even though sterilized, the abnormal accumulation leads to fibrosis, lessened motion and decreased respiratory capacity. Deferred judgment

may lead to desirable surgical treatment of the encapsulated and fibrotic results.

PRIMARY ATYPICAL PNEUMONIA

This is again a specific disease which lends itself to a prompt presumptive diagnosis. Again, listen to the story, look at the patient and the sputum, if any, and count the respiratory rate. An insidious onset with several chills, toxicity less than the fever indicates and a normal respiratory rate are suggestive. In 50% there is also an early relative bradycardia. Toxicity, distention and dilatation of the alae do not occur early. The sputum is scant and white. Physical findings indicating localization are usually deferred several days and are often less than the variable x-ray picture suggests.

It is rather unfair to include this disease under treatment. Sulfonamides, penicillin, streptomycin, or combinations have no established influence. In adults blood or blood fractions have not been helpful. X-ray therapy has not proved worth the exertion to the patient. Secondary pyogenic progress has led to a fair degree of confidence lactic therapy. Unless a specific complication is threatened, penicillin may be discontinued when progress has led to a fair degree of confidence in the diagnosis.

The initial treatment is rest with symptomatic and supportive adjuncts. One hazard is the development of widespread pulmonary infiltration and exudation with cough, dyspnea, cyanosis and a threat of right sided heart failure. Oxygen, low salt intake and mercurial diuretics may then be needed. Digitalis is seldom helpful or advisable. The condition developing gradually in severe cases often reaches its maximum from the 10th to the 14th day which is when the appearance of increased cold agglutinins will often help support the diagnosis. This is a simple test suitable to frequent use and is helpful in 65% to 70% of the cases.

Primary atypical pneumonia could be confused with rheumatic fever pneumonitis. Another hazard is the possible confusion with tuberculosis when the localization is apical. A final diagnosis must be withheld until examinations, progress and total resolution warrant surety.

Prolonged asthenia is frequent. It is stated that if patients are confined to bed until the sedimentation rate is normal the total duration of disability is greatly shortened. This interesting disease of widespread occurrence is a constant stimulus to professional judgment and ingenuity.

BRONCHOPNEUMONIA

Bronchopneumonia is a diagnosis more suitable to the autopsy room than to clinical practice. Clinically it is a disease secondary to a wide variety of causes. The immediate threat is extension, tissue destruction, anoxia and death. The delayed threat is a chronic lung abscess. The ultimate threat with recovery is pulmonary fibrosis and bronchial deformity with reduced respiratory capacity and recurrent episodes of infection.

Treatment is dependent on the basic cause as well as the organisms present. Frequent sputum cultures and smears, progress x-rays and adequate drainage are necessities. Bronchoscopy is often required for both diagnosis and treatment. Even minor attacks in patients with bronchial asthma and emphysema warrant rigorous treatment.

In obstructive bronchopneumonia, the foreign body may be dense or may not be revealed by x-ray. An episode of localized pneumonia less than lobar may be the first evidence of bronchial malignancy which is becoming so frequent and is too rarely diagnosed when curative resection is possible.

The x-ray appearance of acute pulmonary edema may result in an incorrect diagnosis of bronchopneumonia in the early days after cardiac infarction. What appears to be bronchopneumonia with mitral stenosis may be acute pulmonary edema which will promptly disappear when the elevated venous pressure is reduced.

Following pulmonary infarction, medications to relax associated vascular spasm will relieve the strain on the right heart. Localized bronchopneumonia developing after pulmonary infarction may, in some cases, be prevented by therapy instituted at the first evidence of secondary infection.

Adequate early therapy of bronchiolitis may prevent bronchopneumonia.

The treatment of cases secondary to specific diseases, such as measles is the treatment of the disease and the complication.

The realization that inhibition of the cough reflex occurs in debility, coma, alcoholism, etc., should lead to early therapy of beginning disease.

Destructive mixed infection after the aspiration of stomach contents warrants prompt vigorous combined therapy. Pulmonary infiltration

seen following near drowning usually does unexpectedly well.

Inhalant diseases may be acute from gases, volatile metals, etc., and have at times a peculiar delayed but abrupt onset.

Exhalant disease whether from abnormal body chemistry or ingested poisons is apt to be insidious and clinically not easily discovered.

Constant observation of the sputum, its appearance and odor, may reveal lung suppuration before the x-ray reveals rarefaction. Single lung abscesses tend to become complicated within six weeks. The wall becomes more dense and sharply outlined as each day passes. The cure of lung abscess is possible in the first few weeks. Bronchial drainage may be as important as drugs. Penicillin acts in the presence of pus and is effective against the spirochetal organisms present. Gram negative organisms necessitate streptomycin. Staphylococci or streptococci warrant sulfonamides plus penicillin.

Acute pulmonary infiltrations occur with many parasitic or fungal diseases, and in specific diseases such as tularemia, brucellosis, etc. allergic states, pleurisy and effusions have their own indications for treatment.

Direct medicinal therapy of respiratory infections relates to specific known organisms or to mixed infections of unknown types. Indirect or supplemental treatment is dependent on the patient. In general acute respiratory infections are not specific diseases. Persons having acute respiratory infections require careful attention. The patient and his condition, the organism and its location, the reaction and its hazard regulate the therapy.

2799 W. Grand Boul.

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MENINGITIS LOSING ITS STING, ARMY REPORTS

Spinal meningitis, terror of World War I training camps, has today lost much of its menace, according to a report by Dr. Worth B. Daniels submitted through the Office of The Surgeon General of the Army and published in the Archives of Internal Medicine.

The report points out that less than three per cent died of some 14,500 soldiers treated during the World War II period for this once almost hopeless infection. The remarkably low rate was due, Dr. Daniels said, both to the efficacy of sulfadiazine and penicillin in controlling the infection and to quicker diagnosis. Early diagnosis and the prompt use of the drugs can usually stop the spread of the bacteria before they have a chance to become localized in the linings of spinal cord and brain.

Altogether there were about 300 deaths from meningococcic infection in World War II. Approximately ten per cent of these died before the germ had become localized in the nervous system tissues.

The war experience, Dr. Daniels says, shows that sulfadiazine is the best available drug. It is not as effective as penicillin against the bacteria in the blood stream but the latter drug proved to have one great disadvantage. While penicillin circulates through the blood stream freely, it does not get into the cerebrospinal fluid in predictable quantities and hence cannot be relied upon to prevent invasion of brain and spinal cord tissues. Sulfadiazine enters the spinal fluid rapidly in high concentrations.

CASE REPORTS



Precocious Puberty In A Three Year Old Girl

Luis Pavon Sarrelangue, M.D.
Nogales, Sonora, Mexico
Edited by Phebe K. Thompson, M.D., Chicago

The rarity of precocious puberty, and its potentiality for social maladjustment, makes its study an interesting one. The much publicized case in Lima, Peru, in 1940 reminds us of the fact that a girl only five years and eight months of age may have a full-term pregnancy. This report concerns the case of a 3 year old girl who menstruated, had hypertrophied breasts, and showed some of the traits of an adult woman. All these phenomena were corrected by operation.

E.G.L., 3 years old was born in Meza, Arizona. Her parents were healthy and were not related. She was a bright little girl with a normal gait, upright carriage and firm step. Her color was normal, but in spite of her age, she painted her lips and fingernails. Her speech was clear and somewhat rapid.

Her parents stated that a while after birth, the girl exhibited a prepuberal state, characterized by the accumulation of fat tissue in her body, especially in her breasts. Two months previously her breasts had again increased in size, (Figure 1) and irregular menstruation took place. For several days she had had no further menstruation, possibly because of some injections (progesterone?) administered by another doctor. Her parents had also observed an uniform ventral increase in volume, somewhat greater in the lower right quadrant.

The girl exhibited the classic feminine narcissism: she was fond of painting her fingernails and toenails; she demanded that she be allowed to go out walking with her mother; and if permitted, she painted her lips and wore a hat and carried a purse.

She was fond also of having her father caress her breasts, in fact, she asked for this frequently (Electra's complex?). This reaction suggests the establishment of erotogenic zones in the breasts related to a definite sexual desire corresponding to a precocious libido.

The girl was very intelligent. She answered simple questions rapidly but she was reluctant to have a physical examination. She refused to permit examination of her abdomen and genital organs. These reactions appeared to be merely bashfulness. After three attempts, she consented.



Figure 1

A pelvic-abdominal tumor was observed which projected into the right lower quadrant. The examination showed nothing abnormal otherwise. Contrary to what one would expect to find in precocious puberty, she had no pubic or axillary hair, no increase in the size of the pelvis, and no pigmentation of the breasts or external genital organs.

The operation was of a conservative type for the preservation of gynecologic functions. A tumor was found and was removed together with the right tube and ovary. The tumor measured 5 x 4 x 4 (Figure 2). There was some ascites upon opening the parietal peritoneum and the uterus was large (6.5 x 1.5cm). One week later complete wound disruption necessitated closing it again with stainless steel wire. The pathological report classified the tumor as a granulosa cell tumor, typical in some areas, atypical in others because of extensive cystic degeneration of the epithelial nests. (Reports by courtesy of Dr. Emil Novak, Chicago. Figure 4).

Two months after operation (Figure 3) breast hypertrophy had diminished; there was no more menstruation and her psyche was that of an infant. She no longer used lipstick and nail varnishes. With the disappearance of libido and bashfulness, she seemed to be a normal little



Figure 2

girl. Prognosis is doubtful because these tumors sometimes recur.

COMMENT

Precocious puberty is associated with hyperfunctioning tumors of the adrenals, the pineal or the sexual glands. In spite of the predominant role of the hypophysis in the regulation of the sexual mechanism, there are no reports of hypophysical tumor associated with precocious puberty. The case reported here is of the gonadal



Figure 3

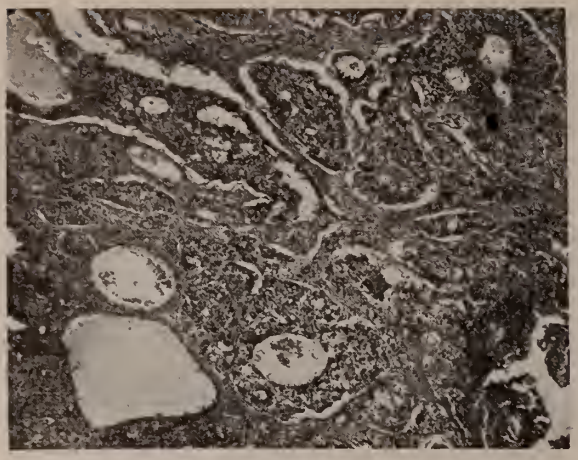


Figure 4

type. It is not common, however, for this type of tumor to cause precocious puberty. In Johns Hopkins Hospital only one case in 60,000 has been reported and it is estimated that no more than 16 cases have been reported in the literature.

We consider puberty to be precocious when it appears during the first nine years of life and certainly if during the first eight years. For this reason our case is interesting because the precocious puberty appeared at three years of age. The mechanism would appear to be phyerestrogenism caused by the tumor. There is no urinalysis to support our guess, but the symptoms and their disappearance after removal of the tumor support our theory.

If she survives, it would be interesting to observe what influence, if any, these experiences have on her at the time of normal puberty. Would she remember her past condition? Would the incipient Electra's complex reappear at this time?

It is necessary to take extra precautions to protect these girls against violation invited by their increased libido.

ACKNOWLEDGEMENT

We wish to express our gratitude to Dr. Paul Novak of the Registry of Ovarian Tumors and the Drs. R. Archibald and Richard W. TeLinde of Johns Hopkins for the valuable help given.

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CURING COMMON WARTS

Common warts on the glabrous skin are cured with greatest certainty by destructive measures. My personal preference is for electrodesiccation. After anesthesia with procaine, the wart is desiccated until it turns white. The end point is when a certain sudden incandescence occurs beneath the wart. Then with manicure scissors the wart is freed from the normal skin around it, after which the base is thoroughly curetted.

If electrodesiccation is not available, a fine tipped actual cautery can be used. If neither is available one can free the wart with fine scissors, curette the base thoroughly and paint the dry base with pure phenol. With any of these methods some scarring is apt to result, of which the patient should be warned in advance. If it is desirable to avoid all scarring and an open wound, x-ray or radium may be used.

Both of these are excellent treatments for warts even though the 72 per cent rate of cure reported by the Mayo Clinic following their use is definitely lower than that obtained by destructive measures.—H. J. Templeton, M. D., in California Medicine.

NEWS OF THE STATE



COOK

New Orthopedic Officers.—Dr. Fred Shapiro was chosen president-elect of the Chicago Orthopedic Society at a recent meeting. Dr. John R. Norcross was installed as president. Other officers are: Doctors Arthur H. Conley, vice president; Manly A. Page, secretary-treasurer; and Sam Banks, assistant secretary.

Branch Meetings.—James A. Eldridge, midwest field director of the American Association for the United Nations, discussed "Western European Union" before the North Shore Branch of the Chicago Medical Society, October 5. The North Suburban Branch was addressed October 11 by Drs. Andrew C. Ivy and Warren H. Cole on "Newer Concepts of Peptic Ulcer." Discussants were Drs. Frederick Christopher and Robert W. Keeton. The South Side Branch heard Dr. Martha R. Folk, October 14, on "Ophthalmology in Relation to Pediatrics." Dr. Carl F. Steinhoff discussed "Medical Aspects of Atomic Energy" before the Calumet Branch, October 15. "Acute Respiratory Infections" was the theme of a discussion before the Douglas Park Branch, October 19, by Drs. E. B. Freilich, Phil Aries and L. S. Tichy. Dr. W. Allen Conroy addressed the Southern Cook County Branch, October 19, on "Modern Advances in Anesthesiology."

Appointment at Illinois.—Dr. Maurice Lev has been appointed assistant professor of pathology at the University of Illinois College of Medicine on a full-time basis, Dean John B. Youmans announced recently.

Dr. Lev previously served as a research associate in pathology and as director of research in the department of pathology at Michael Reese hospital.

He is the author and co-author of approximately 20 significant articles dealing with pathologic investigations. He has been particularly interested in congenital malformation of the heart and other disorders of the cardio-vascular system.

Dr. Lev is a graduate of New York University and Creighton University College of medicine. During the war, he served as commanding officer of the 4th Medical Laboratory and was discharged from the Army with the rank of Lieutenant Colonel. He held the position of assistant professor of pathology at Creighton University School of Medicine in 1946-47.

The Belfield Lecture.—Dr. Charles P. Mathe, San Francisco, gave the twentieth annual William T. Belfield Memorial Lecture of the Chicago Urological Society at its meeting in the Congress Hotel, October 21. Dr. Mathe's subject was "Operative Interventions on the Solitary Kidney." Other meetings of the society this year will be held December 2, January 27, March 24, and April 28. This year the society plans to have the urological residents at the various hospitals give five minute talks on interesting cases prior to the regular programs. Officers of the society are Dr. James W. Merricks, president; Dr. James I. Farrell, vice-president and Dr. J. S. Grove, secretary-treasurer.

Personal.—Dr. Allen W. Glinert, specialist in internal medicine and tuberculosis work, has joined the Chicago State Hospital staff as physician in charge of tuberculosis service. A native of Jugoslavia, he received his medical education at the University of Vienna. As a prisoner during World War II, he was a physician at the Moosburg, Ger-

many, POW hospital from 1941-1945.—Dr. Thomas Kallal was recently appointed acting president of the Cicero town board.—Dr. Elmo E. Dillon, Homewood, was awarded the Order of Honor and Merit of the Republic of Haiti, August 24. The decoration was bestowed on Dr. Dillon by the Ambassador of Haiti in the Embassy in Washington, D. C., in appreciation of Dr. Dillon's ophthalmological care of Dr. Maurice Sixto, a Haitian university professor.—Dr. Klaus R. Unna, associate professor of pharmacology, University of Illinois College of Medicine, went to Hamburg, Germany, September 16, where he was guest lecturer at the International Dermatological Congress on September 23-26. He spoke on "Recent Advances in Antihistamine Therapy." Partial travel expenses have been granted through the generosity of Hoffman-La Roche, Ciba Pharamceutical Company and Abbott Laboratories.

Society News.—The Chicago Medical Society was addressed September 22, at the John B. Murphy Memorial Auditorium, by the following speakers: Dr. Alford W. Adson, Rochester, Minn., on "The Diagnosis and Treatment of Cervical Ribs and Scalenus Anticus Syndromes" illustrated with slides and movies; Dr. Russell L. Cecil, New York City, on "Psoriatic Arthritis" and Karl Paul Link, Ph.D., Madison, Wis., on "Can We Look Forward to Better Anticoagulants Than Heparin and Dicumarol"—At a special meeting of the Chicago Society of Allergy, September 23, the speakers were Dr. Bernard N. Halpern, Paris, France, on "Antihistamine Compounds: Evolution and Pharmacology" and Earl Loew, Ph.D., Lombard, on "Present Status of Antihistamine Drugs." The introduction was conducted by Dr. Samuel M. Feinberg, Chicago. —Dr. Philip Thorek, Chicago, addressed the eighty-third annual session of the Michigan State Medical Society in Detroit, September 22, on "Acute Abdominal Emergencies."

University News.—Dr. H. Worley Kendall, professor of medicine, University of Illinois College of Medicine, gave an assembly hour lecture at the University, October 6, on "The Growth of Physical Medicine."

Assistant Dean Named at Illinois.—Dr. Robert C. Berson of Rye. N. Y., has been appointed assistant dean of the University of Illinois College of Medicine.

Dean John B. Youmans announced that Dr. Berson also would serve as assistant director of clinics for the University of Illinois hospitals. Dr. Berson has been an attending physician at the United Hospital, Port Chester, N. Y. He was attached to the 300th General hospital during the war, receiving his discharge in February, 1946, with the rank of major. Dr. Youmans also has announced the appointment of Dr. George R. Minor of Charlottesville, Va., as an assistant professor of surgery. Dr. Minor has served on the staff of the University of Michigan Medical School as an instructor in thoracic and general surgery since 1945.

Dr. Anson Opens Brodel Lectures.—Dr. Barry J. Anson, professor of anatomy, Northwestern University Medical School, gave the first of a series of lectures endowed by the late Dr. Max Brodel, Baltimore, founder of medical illustration in the United States. Dr. Anson, in his first lecture, reviewed the work of Andreas Vesalius and spoke a dinner meeting, September 27, opening the third annual convention of the Association of Medical Illustrators.

New Administration at Loyola's University Hospital.—Announcement was recently made of a new administration board for the University Hospital of the Stritch School of Medicine of Loyola, consisting of Dr. James J. Smith, dean of the medical school, Walter A. Wade and John J. Waldron, attorneys, and L. F. Grapski, the hospital's present administrator, and Dr. Charles Thill, clinical dean of the medical school, will become medical director of the institution.

Allergy Orientation Course.—The Northwestern University Medical School, with the sponsorship of the American Academy of Allergy, offered an orientation course in clinical allergy from October 25-29, in Thorne Hall on the Chicago campus of the University.

Registration was limited to members of the medical profession and the course was directed by Dr. Samuel M. Feinberg, associate professor of medicine at Northwestern and head of its newly established Allergy Research Laboratory. Dr. Feinberg presided at the opening session at which the remarks of welcome were made by Dr. J. Roscoe Miller, dean of Northwestern University Medical School.

Fourteen of the faculty of 27 for the course are members of the University's medical faculty. They are Drs. Theodore B. Bernstein, associate in medicine (allergy); John A. Bigler, associate professor of pediatrics; Carl A. Dragstedt, professor and chairman, department of pharmacology; William J. Ford, instructor in medicine (allergy); Newell C. Gilbert, professor and chairman, department of medicine; Leonard H. Harris, clincal assistant in medicine (allergy); Saul Malkiel, assistant professor of medicine and director of research, Allergy Research Laboratory; Edward A. Oliver, professor and chairman, department of dermatology; Simon S. Rubin, instructor in medicine (allergy); Karl F. Urbach, instructor in pharmacology; William B. Wartman, professor and chairman, department of pathology; J. A. Wells, associate professor of pharmacology; Guy P. Youmans, associate professor of bacteriology; and Dr. Feinberg.

Grant for Study of Epilepsy.—The Junior League of Chicago, Inc., has presented a $13,000 grant to the University of Illinois College of Medicine toward the support of the Consultation Clinic for Epilepsy.

The Clinic, operated by the University's department of psychiatry at the Illinois Neuropsychiatric Institute, is directed by Dr. Frederic A. Gibbs, and

supervised by Miss Betty Vilas. Drs. John S. Garvin and Pauline Cooke are the attending physicians. Two members of the clinic staff are Junior League members, while Volunteers give additional aid.

Two state divisions, the Division of Services for Crippled Children and the Division of Rehabilitation, have joined in the support of this project by referring patients and contributing financially to the Clinic.

The Junior League has taken the Consultation Clinic as a demonstration project to meet an urgent and neglected need in the community. It is hoped that other consultation clinics of this same type will be formed in other states.

James Roscoe Miller Chosen President of Northwestern.—Dr. James Roscoe Miller, dean of Northwestern's Medical School, has been elected president of Northwestern University and will assume office on July 1, 1949, it was announced September 28, by Kenneth F. Burgess, president of the board of trustees.

Dr. Miller will become the twelfth president of the University, succeeding Franklyn B. Snyder, president since 1939, who will retire September 1, 1949 at the age of sixty-five in accordance with the University's retirement policy.

Dr. Miller, who was born in Salt Lake City in 1905. received his A.B. degree from the University of Utah in 1925. He studied medicine at Northwestern University Medical School, which awarded him the M.D. degree in 1930 and the M.S. in 1931.

He has been a member of the Medical School's teaching staff since 1930 and served as assistant dean of the School from 1933 until his appointment as dean in 1941.

During the war he was a Commander in the Medical Corps, U.S. Navy, in charge of the Section on Internal Medicine of the Professional Division, Bureau of Medicine and Surgery, Washington, D.C.

Dr. Miller is now president of the Chicago Medical Society, president-elect of the Association of American Medical Colleges, a trustee of Wesley Memorial and Passavant Memorial Hospitals, a trustee of the Evanston Hospital, and a member of numerous medical societies and associations.

Dr. Miller will become the second alumnus president of Northwestern University. The first alumnus to achieve this honor since the University was founded in 1851 was Walter Dill Scott, president emeritus of the University.

Activate Hospital Reserve Unit.—A 1,000-bed hospital reserve unit, the 427th General Hospital, has been activated by the U. S. Army, under the sponsorship of the University of Illinois College of Medicine. Dr. John B. Youmans, dean of the College of Medicine, has been appointed commanding officer of the hospital. Dr. Youmans, a colonel in the Army Medical Corps Reserve, served as director of the nutrition division, preventive medicine service, Office of the Surgeon General, during the war. The class "C" type service unit will consist of a full complement of officers. Commissioned personnel will include 55 medical, dental, and administrative officers and 83 nurses. Monthly training periods have been planned for personnel assigned to the hospital. In the event of mobilization, the hospital would be fully staffed in a minimum of 180 days. Filler personnel would be assigned through Selective Service or from those who hold reserve appointments. Dr. Youmans has announced that Dr. George V. Byfield has been appointed chief of medical service for the hospital, while Dr. William E. Looby will serve as chief of the surgical service. Both Dr. Byfield and Dr. Looby are members of the University of Illinois faculty and serve on the staff of the Veterans Administration Hospital at Hines. Others who have been appointed by Dr. Youmans are Victor E. Nicklas as adjutant and Joseph W. Harney as psychologist.

The history and battle honors of the 27th Evacuation Hospital which was sponsored by the University of Illinois during World War II have been transferred to the new unit. The 27th Evacuation Hospital cared for 21,000 patients in almost two years service in the Mediterranean and European theatres.

The 427th is one of two general hospitals sponsored by institutions in the Chicago area which have been activated. The 297th General Hospital has been organized under the sponsorship of Cook County Hospital.

Ceremonies at Evanston Hospital.—Groundbreaking ceremonies for a 92-bed addition at Evanston Hospital took place October 1, marking the starting of a $7,000,000 expansion program for the hospital. Franklyn Bliss Snyder, president of Northwestern University, gave the principal address.

Dr. Kordenat Goes to Texas.—Dr. Ralph A. Kordenat, formerly associate professor of surgery, University of Illinois College of Medicine, has been appointed to the medical staff, Dallas, Texas, branch office of the Veterans Administration, and will assist in the supervision of the Veterans Administration surgical service in Texas, Louisiana and Mississippi hospitals with permanent headquarters in Dallas. Dr. Kordenat graduated at the University of Illinois College of Medicine in 1922 and did postgraduate work in London and Berlin. He is one of the founders of the American Board of Surgery. He served during World War I in the United States Army and during World War II was vice chairman of the Procurement and Assignment Service for Physicians in Illinois.

Course in Basic Otolaryngology.—Thirty-three physicians, including representatives from Brazil, Guatemala, and Canada, have enrolled in a postgraduate course in "Basic Otolaryngology" which began at the University of Illinois College of Medicine Oct. 4.

The full-time course of instruction designed for physicians preparing themselves for special practice will continue through June 18, 1949.

The course consists of lectures, demonstrations, cadaver dissection, surgical anatomy, physiology, bacteriology, laboratory and photographic technique, histology, and pathology.

The Ransom Lecture.—Dr. George M. Lyon, Washington, D.C., chief of the radioisotope section, department of medicine and surgery, Veterans Administration, delivered the Ransom Lecture on "The Radioisotopes in Medicine", October 22, at the Archibald Church Library of Northwestern University Medical School. The lecture was sponsored by the Theta Chapter of Phi Beta Pi Fraternity.

CUMBERLAND

Baby Parade Honors Physician.—Dr. W. R. Rhodes, who has served the residents of Toledo for forty-four years, was guest of honor at a parade October 2, of all the "babies" he had delivered since 1904. The day was designated as "Rhodes Day" and prizes were awarded to the youngest baby, the largest family of "Dr. Rhodes babies" and any three generation family taking part, according to the Robinson News.

DE WITT

Miscellaneous News.—Dr. William R. Marshall, Clinton, secretary of the De Witt County Medical Society, submits the following information: The De Witt County Medical Society members just completed a county-wide immunization campaign. They were assisted by the county health committee and the nurses from the De Witt-Piatt county health unit. Most of the members of the society have returned from their summer vacations and are back at work again. The regular monthly meetings of the medical society were started again following the summer vacation. Mrs. Bogardus, wife of Dr. Charles Bogardus, Clinton, passed away in the John Warner Hospital after a short illness. One of the State department mobile X-ray units spent the greater part of November in De Witt county. The county school boards are requiring compliance of the State law that students starting the fifth and ninth grades have a physical examination.

DOUGLAS

Personal.—Dr. James Taylor, Villa Grove, was recently named coroner of Douglas County succeeding the unexpired term left by the death of his father, Dr. R. W. Taylor.

EFFINGHAM

Fifty Years of Practice.—Dr. H. Taphorn, Effingham, was presented with the certificate and gold emblem signifying his completion of fifty years in the practice of medicine and making him a member of the Fifty Year Club of the Illinois State Medical Society. The presentation took place during a meeting of the Effingham County Medical Society. Included among the speakers were Dr. Andy Hall, Mount Vernon, and Dr. Louis Limarzi, Chicago. The former discussed medicine fifty years ago and Dr. Limarzi, hematology from the standpoint of the general practitioner.

FORD

Physician Retires.—Dr. John A. Coulteaux, who had practiced in Roberts for the past thirty-seven years, has sold his practice to Dr. C. A. Fulison of Paxton. He and his wife plan to take up their residence in Pasadena, California.

FULTON

E. K. Dimmitt Chosen Oustanding Practitioner.—Dr. E. K. Dimmitt, Farmington, was selected as the outstanding general practitioner in Fulton County by the Fulton County Medical Society at a dinner meeting, September 17. Another feature of the meeting was the presentation of certificates by Dr. E. P. Coleman, Canton, for fifty years of service to Dr. Maud T. Rogers, Canton, and Dr. George S. Betts, Banner. The principal scientific speaker for the evening was Dr. B. C. Kilbourne, Chicago, who discussed "Fractures of the Hand."

GREENE

Society News.—Dr. Normal L. Baker, Springfield, lectured on the "Treatment of Fungus Infections of the Skin" before the Greene County Medical Society and the dentists of the county, in White Hall, September 10. The members present were Dr. F. E. Walker, Dr. N. J. Bucklin, Roodhouse; Dr. W. T. Stickley, Dr. R. W. Piper and Dr. F. N. McLaren, White Hall; Dr. C. A. Billings, Hillview; and Dr. A. K. Baldwin and Dr. A. D. Wilson, Carrollton. The dentists present were H. C Haynes, White Hall, and Frank Veith, Roodhouse. Included among the visitors were Mrs. F. N. McLaren, Mrs. A. D. Wilson, Mrs. A. K. Baldwin and Mrs. N. L. Baker. Dr. W. H. Garrison, White Hall, is secretary of the society.

HENRY

Wilbur Spencer Retires.—Dr. Wilbur F. Spencer, Geneseo, eighty-four years of age, closed his office October 1. Dr. Spencer, Geneseo's oldest practicing physician, has practiced medicine in the town for fifty-seven years.

KANKAKEE

Physician Chosen "Outstanding Practitioner."—Dr. S. R. Walker, a practicing physician in Chebanse for fifty-nine years, was recently chosen the outstanding practitioner in the county by the Kankakee County Medical Society. A charter member of the county medical society and one of its organizers, Dr. Walker went to Chebanse in June, 1889, following completion of medical studies at Queen's University Faculty of Medicine, Kingston, Ontario, Canada, and has been a practicing physician in that community since. He is still active in his practice and regularly attends meetings of the society. He is regarded as the oldest practicing physician in the county in point of service. Dr. Walker is one of the most civic-minded persons in the county and particularly in his community, having served as mayor of the village of Chebanse for more than thirty years. He is still active in this capacity. A past president of the

Kankakee County Medical Society, Dr. Walker has also held the office of first vice president.

Home Town Honors Edwin Hamilton.—On Thursday evening, September 30, the Kankakee County Medical Society acted as hosts for a dinner meeting arranged to honor Edwin S. Hamilton, who was recently elected as resident trustee of the American Medical Association. Although this was primarily intended as a home affair, and only a small number of invitations were sent to medical friends and associates of Doctor Hamilton, there were actually about 240 present.

Dr. Charles Ruch, as President of the local Society, acted as presiding officer to introduce several local men who made short talks relative to the guest of the evening. Among these were two senators, two representatives in the Illinois legislature, and representatives of the dental and legal professions desiring to give their tribute to Doctor Hamilton. As chief of staff of St. Mary's Hospital over a period of some 15 years, several officials of the hospital were present, and were likewise presented.

Dr. Harold M. Camp, Secretary, Illinois State Medical Society, presented the medical men from outside Kankakee County who were present, first introducing Dr. and Mrs. R. L. Sensenich, South Bend, Indiana, Dr. and Mrs. Ernest E. Irons, Chicago, Dr. and Mrs. Josiah J. Moore, Chicago, Dr. Louis H. Bauer, Hempstead, Long Island, Dr. James R. Miller, Hartford, Connecticut, Dr. and Mrs. Harry M. Hedge, Chicago, Dr. and Mrs. James H. Hutton, Chicago and Dr. and Mrs. Charles H. Phifer, Chicago.

This group represented the President, President-Elect, Treasurer, and two members of the Board of Trustees of the American Medical Association, the Chairman of the Council, and two past presidents of the Illinois State Medical Society. Doctor Camp called upon Doctor Sensenich to tell of medical, health and economic conditions in Europe, he having returned from a "Mission" tour of Great Britain and the Continent during the past week. This was a most interesting talk, and the group received information concerning present conditions in this part of the world. In Germany today physicians receive 20 cents for office visits of patients, 30 cents for residence calls in the daytime and 50 cents for night calls. He told of the deplorable state of medical educational facilities, hospitals inadequacies, and the poor types of service the sick were receiving in this area, and particularly the occupied areas in Germany.

Doctor Irons was asked to tell of his recent trip to Japan, as a member of a mission to that country. These missions were arranged by the Surgeons General, and the State Department of the U. S. Government, to get first hand information concerning medical and health conditions in the various countries. The trip to Japan made by air required three days from Chicago going to Japan, via Hawaii, Wake Island, to Tokyo, and the return trip via the Aleutians required slightly more than two days, this trip being some 3,000 miles shorter than the one taken to Tokyo. Great tribute was paid to General McArthur and his work in Japan, and those making the mission tour were received everywhere most courteously.

Louis H. Bauer, recently returned from Europe, where he attended the meeting of the World Medical Association, of which he is now the Secretary. With some 29 nations represented, he told of many interesting things which were reported at this session. Most of the problems of the other countries are not met at all in the United States, and there was a general feeling that the U. S. physicians were the only ones who were permitted to practice medicine as a free enterprise.

He told of the lack of legal requirements in many countries, and the confusion which arises as a result of so many illegal and inadequately trained physicians now in practice. He had a definite opinion that the World Medical Association is going to do much for physicians in many foreign countries, and the U. S. has an opportunity to aid materially in its development, and operation in the future. Much information relative to this conference will appear in the Journal of the A. M. A. in the next few weeks.

Dr. James R. Miller was one of three official delegates sent by the United States to attend the conference of the World Health Organization (W. H. O.), held quite recently in Geneva. He told of the value of this organization, and the part this country can play in its operation. He stated that last year we sent some 70 million dollars to European countries for the care of infants and children, and this work can be done more satisfactorily under supervision of the W. H. O.

During the evening a presentation of matched luggage was presented to Mrs. Hamilton by the Kankakee County Medical Society, then a similar matched set was presented to Doctor Hamilton. It was suggested that because it seems quite popular today to have officers and members of the A. M. A. Board of Trustees go on missions to various foreign countries, it might be well for him to be prepared to take all necessary clothing, and consequently he should have something to take it in upon such occasions.

Before the meeting ended, Doctor Hamilton was asked to say a few words, and he told how happy he was to have the home folks honor him in this way, and likewise to see so many friends from the A. M. A. official family, and his own state medical society present on this occasion. He insisted that he proposed to do everything possible to carry out his assignments in the new capacity of resident trustee, although he would continue to maintain his interests and work in his own state, and county medical society as well, and he was firmly of the opinion that the basic units of our medical organization are the ones which must not be neglected.

Without strong county and state societies, we could not expect to have a strong American Medical Association. He told the home folks that his several committments now require him to be away from home a considerable part of the time, and this new appointment will mean more time away, but he would continue maintain an office and see his patients who are tolerant, and who realize that he must be away perhaps many times when they would like to have him care for them.

The meeting was arranged by the Kankakee County Society without the consent of Doctor Hamilton, and only after the preliminary arrangements were made, was he informed that it was to be held, and he was consulted then, only to be sure that a date could be selected to meet with his approval.

Even though everything was arranged for this date, Doctor Hamilton had spent the entire day at an important meeting of the Board of Trustees in Chicago, arriving home only in time to greet the large group which met to honor him.

MACON

Society News.—At a dinner meeting of the Macon County Medical Society, September 28, Dr. Howard A. Lindberg, assistant professor of medicine, Northwestern University Medical School, discussed "Hypertension: Medical and Surgical Aspects."

MADISON

Society News.—Dr. Frederick V. Emmert, St. Louis, discussed "Endocrine Treatment of Functional Uterine Bleeding" before the Madison County Medical Society, October 7, at the Edwardsville Gun Club, Edwardsville.

PIKE

Dr. Stevenson Discusses Socialized Medicine.—At a joint meeting of the Calhoun and Pike County Medical Societies in Griggsville, recently, Dr. Walter Stevenson, Quincy, President-Elect of the Illinois State Medical Society, spoke on "Socialized Medicine."

PEORIA

Personal.—Dr. Robert Rutherford was recently nominated to succeed Dr. Charles G. Farnum Jr. as medical director of St. Francis Community Clinic, a Red Feather agency of the Community Chest. Dr. Farnum was named honorary medical director and Dr. Robert Fey was made assistant to Dr. Rutherford.

Society News.—Dr. Warren B. Cooksey, Marquette University School of Medicine, Milwaukee, Wisc., addressed the Peoria Medical Society, September 21, on "Edema in General and Nephrosis."

ROCK ISLAND

Health Program Expanded at Augustana College.—Fifteen local physicians were cooperating in giving health examinations to approximately four hundred freshmen students at Augustana College, Rock Island, recently, as a part of the expansion of the health program at the school. The college administrative board recently announced a new accident and health insurance plan which already has gone into effect. The cost of the insurance is included in the health fee paid by each student at the time of registration, according to the Rock Island Argus. The plan is designed exclusively for Augustana students and will reimburse students for medical expenses up to $500 for any accident or sickness which disables them during the school year. Students will be protected for the entire school year at school or elsewhere including vacations. The doctor or surgeon, as well as the hospital, may be selected by the student.

SANGAMON

Society News.—At a meeting October 7 of the Sangamon County Medical Society, Dr. Samuel G. Taylor, III, assistant professor of medicine, University of Illinois College of Medicine, discussed "Androgen Therapy of Advanced Carcinoma of the Breast."

ST. CLAIR

Symposium on Obstetrics and Gynecology.—A symposium on obstetrics and gynecology was sponsored by the St. Clair County Medical Society, October 7, at St. Mary's Hospital, East St. Louis. The speakers, all of whom are Chicago physicians, were Dr. Joseph B. Teton, on "Culdoscopy"; Dr. John R. Wolf, "Vaginal Bleeding in the Forties"; Dr. A. J. Mauzey, "Observations on Pregnandiol Excretion" and Dr. Charles D. Krause, on "Postpartum Hemorrhage." The evening speaker was Dr. Charles Newberger who spoke on "Vital Message to All Interested in Medicine." The guest speakers were introduced by Dr. Edward W. Cannady. Dr. W. C. Scrivner is president of the society.

WARREN

Crippled Children's Clinic.—Dr. Richard Bennett, Chicago, conducted a clinic for crippled children recently under the auspices of the Warren County Medical Society and in cooperation with the Warren County chapter of the National Foundation for Infantile Paralysis. The recent clinic is one in a series held twice a year and which have been conducted in Warren County for some twenty-eight years. Dr. James Firoved, Monmouth, is chairman of the committee for the Warren County Medical Society and Dr. Joseph Sherrick chairman of the Warren County Chapter of the infantile paralysis organization.

GENERAL

Report of Mental Hygiene Society.—"Because We Believe" is the keynote of the 1947 annual report of the Illinois Society for Mental Hygiene recently made available. The report discusses the various activities that are sponsored by the society, emphasizing the educational and legislative program that was inaugurated in 1947. The first tangible result of the society's efforts to expand psychiatric facilities in Illinois was the opening, March 21, 1947, of the Mental Hygiene Clinic at the Women and Children's Hospital, Chicago. This clinic, largely financed by the Community Fund of Chicago, provides low cost psychiatric care to the "psychiatrically indigent."

The activities of the local societies in Winnebago and Sangamon Counties are discussed. The Illinois Society for Mental Hygiene was founded in 1909 as the second mental society in the United States. Its program in 1948 was focused on the mental hygiene needs of children: an educational program for parents and teachers, out-patient services for mildly disturbed children, and specialized institutional facilities for children with serious behavior disorders and mental illness.

GENERAL

Illinois Physicians in Out of State Activities.—At the InterState Postgraduate Medical Association of North America meeting in Cleveland, November 9-12, the following Illinois physicians spoke: Dr. Herman L. Kretschmer, "The Treatment of Bladder Neck Obstruction and Evaluation of Various Methods in Use Today" and on "Medicine and Philately"; Dr. Derrick Vail, "Exophthalmos" (The Schneider Foundation Eye Presentation): Dr. Warren H. Cole, "Gallbladder Disease"; Dr. Philip Lewin, "Painful Conditions of the Foot and Ankle" and Dr. Geza de Takats, "The Emergency Treatment of Apoplexy." —Dr. Wayne B. Slaughter, Chicago, discussed "Alar Deformity Due to Hare Lip" among other speakers before the annual session of the American Otorhinologic Society for Advancement of Plastic and Reconstructive Surgery, Inc., at the Palmer House, Chicago, October 9.

Academy of General Practice Holds First Meeting.—The first annual scientific assembly of the Academy of General Practice will be held in Cincinnati at the Netherlands Plaza Hotel, March 7-9, 1949. The assembly will open at 9:00 a.m. on Monday, March 7, with an invocation and greetings from representatives of the mayor of Cincinnati and the local medical society. The opening general session will be closed with the presidential address of Dr. Paul A. Davis. The first scientific paper will be presented at 9:30 a.m. On Monday evening, there will be a dinner for secretaries and presidents of constituent state chapters. The annual banquet for all members, their wives and friends will be held on Tuesday evening. The meeting will close at noon Wednesday, March 9. The congress of delegates will meet at 10:00 a.m. Sunday, March 6, preceding the assembly and again, for its second session, on Tuesday afternoon. Non-members of the Academy may attend the assembly as guests on payment of a registration fee of $5.00. Only doctors of medicine may register. There will be no registration fee for members. Members wishing to make reservations now may do so by addrssing the Chairman, Sub-Committee on Hotels, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.

Course in Physical Medicine.—The second three-month course of instruction in Physical Medicine and Rehabilitation is being given at the Veterans Administration Hospital, Hines. It was recently announced that nineteen physicians from various Veterans Administration hospitals throughout the country, and one army physician, are enrolled in the course which started September 20 and continues until December 11. This course is under the direction of Dr. Louis B. Newman, chief of the Physical Medicine Rehabilitation Service at the Veterans Administration Hospital, Hines, where Dr. K. A. Carroll is manager.

Remembrance Fund.—The Illinois Heart Association has recently established a Remembrance Fund at the request of those who wish to give living memorials that will go far beyond the gift in service. Gifts may be sent to the Remembrance Fund as memorials upon the death of a loved one, or for the happy occasion of birthdays, anniversaries, and special days deserving tribute. Money so received will be used for research, education and community service for the benefit of the victims of heart disease, which now directly affects some ten million Americans, and indirectly many more. When Memory Gifts are received, the Illinois Heart Association will send at once an appropriate letter to the person honored, or to the relatives in the case of memorial contributions. The name of the donor or donors will be stated, and the purpose of the gift, but the amount will not be mentioned. A receipt-acknowledgment is also sent to the donor. The Illinois Heart Association is located at 203 North Wabash Avenue, Chicago 1.

Prize Offered for Article on Medical Research.—A $500 Prize will be awarded by the National Society for Medical Research for the best article published in a popular magazine during the period January 1, to May 1, 1949, which describes the growth of a medical development including an account of the experimental work leading to its realization. A full understanding of *how* medical knowledge is gained is essential to full popular support of medical research, medical teaching and medical practice.

When understanding supplants ignorance, anti-science cults like the anti-vivisectionists will wither and die.

To stimulate the writing and publication of accounts which tell the *full* story of medical research—including the role of experimental animals — the National Society for Medical Research will award $500.00 to the author, or authors, of the best article published in a popular magazine during the period January 1, to May 1, 1949, and describing fully the animal experimentation background of medical achievement.

The Society will assist authors in the placement of articles.

The judges of the competition will be announced later.

For complete details and entrance blanks write to: National Society for Medical Research, 25 E. Washington St., Chicago 2, Ill.

News From The Department of Public Welfare.—The population in all institutions of the Department of Public Welfare August 31, 1948, was 46,690, an increase of 1,865 over August 31, 1948. On the books of all institutions including those present, in family care, conditional discharge, unauthorized absence and all other absences were 53,649. The greatest increase over August of last year was in the nine hospitals for mentally ill, the population of which rose 1,684. There were 1,173 admissions as compared to 1,008 in August, 1947. There were 657 discharges and 283 deaths during the month. In these hospitals there were 34,358 patients and a total of 37,679 on the books. The institutions for mental defectives — Dixon State Hospital and Lincoln State School and Colony showed an increase of 237 over the previous year. The population was 9,237 with 10,620 on the books. There were 382 in Security Hospital, an increase of 6 over the previous year. At Neurosychiatric Institute where most admissions are temporary for special treatment, 69 patients were present August 31, 1948. Clinics for trachoma control and prevention of blindness in southern Illinois provide treatment for trachoma, glaucoma and other eye diseases. During August, 213 received treatment for trachoma, 51 for glaucoma and 463 for other eye ailments. Twenty-six were hospitalized for operations. The Chicago Community Clinic reported 478 interviews for the month. Of these, 454 were formerly patients in state hospitals, 201 at Elgin and 174 at Manteno. The Eye and Ear Infirmary listed 18,737 treatments. In August, 88 persons were admitted to the hospital. The Welfare Institutions reported 1,392 new dental cases and 5,574 old cases for August.

The Boys' Training School, Girls' Training School and Women's Reformatory reported 867 juvenile delinquents, felons and misdemeanants present August 31, a decrease of 177 as compared to one year ago. There were 649 juvenile delinquents present at the close of the month as compared to 795 a year earlier. Since students of the Schools for the Blind and Deaf were on summer vacation on August 31, these institutions are not covered in this report. There were 243 children at the Soldiers' and Sailors' Children's School. The Children's Hospital-School for physically handicapped children had an enrollment of 90. Eighty children were present, an increase of 55 over one year ago. The Industrial Home for the Blind, Soldiers' Widows' Home and Soldiers' & Sailors' Home reported 1,356 present, an increase of 122 over one year ago. The Veterans' Rehabilitation Center in Chicago, and the Veterans' Clinics in Urbana and Aurora received 66 new cases during the month. There were 870 visits to the clinic in Chicago, 116 in Urbana and 24 in Aurora. Since opening the centers, 4,688 veterans have received treatment in Chicago, 131 in Urbana and 37 in Aurora. The Division of Veterans' Service reported 2,777 veterans present in all state Welfare Institutions August 31. The Institute for Juvenile Research interviewed 194 new cases, 90 from Cook County and 31 from Cook County Juvenile Court in August. A total of 556 children and 674 adults old and new cases, were examined and received treatment. The Division of Supervision of Delinquents affected 49 placements during the month. These were in boarding fund homes, boarding homes, free homes and wage homes.
In addition 1,006 patients were interviewed in outpatient clinics and there were 1,759 visits to these clinics.

HEALTH DEPARTMENT ACTIVITIES

New Funds Sought for Chicago Health Department.—Substantial expansion of the health protective activities of the Chicago and Cook County health departments in 1949 is the principal immediate objective of the Committee on the Chicago-Cook County Health Survey.

The committee, which is sponsored by the Health Division of the Council of Social Agencies of Chicago, was formed to work toward the adoption of the many recommendations of the health survey made last year for the improvement of the health facilities of the metropolitan area. Chairman is Samuel A. Goldsmith, director of the Jewish Charities.

Because of the magnitude of the task, in the face of the financial difficulties of the various governmental units of city and county, the committee has chosen only what health experts consider the most fundamental and essential to present to responsible officials for action in 1949.

The principal expansion sought for the Chicago Health Department, the committee's announcement said, is the addition of 50 public health nurses, or as close to that number as can be recruited, in view of the shortage of nurses.

The second great need is for sanitary inspectors, of whom 25 more are recommended, while the third is for 12 dentists and three dental hygienists.

In fourth place, but of equal importance, the committee rated the development of new activities which were begun at the recommendation of the Survey under the 1948 budget. The Health Department now has divisions of nutrition, health education, mental hygiene, geriatrics and adult hygiene and public health statistics, as well as a beginning of the district health center system which should all be strengthened and given broader scope, the committee believes.

In all, the committee pointed out, the Chicago Health Department should have in 1949 approximately 175 additional personnel, professional and clerical, and a total of $600,000 additional in 1949 to cover their salaries, equipment and expenses and to give some of many needed pay adjustments.

Regarding the Cook County Department of Public Health, in conferences with the health committee of the County Board, the committee has suggested that recommendations intended to produce a modern, full-scale health program in the county be divided over four years.

Thus the committee asked that the County Board appropriate for about forty additional personnel, professional and clerical, in 1949. It has also suggested joint operation with the city of the vital statistics program to save funds and improve efficiency and it has asked that the possibility of obtaining certain federal funds be investigated.

In addition, the committee is seeking from the city immediate strengthening of the housing program, especially in the improvement of inspection services; a more aggressive rodent control program and continued effort to improve garbage collection and disposal.

A number of lesser activities, many of them not involving increases in budgets, are also on the committee calendar. In some such activities, the committee is co-operating with agencies especially active in the respective fields.

Funds for Mental Hygiene.—The Advisory Committee to the Mental Hygiene Section of the Chicago Health Department recently approved the allocation of $24,175.00 in federal funds to expand psychiatric and mental hygiene clinics in Chicago. Clinics at Mercy, Provident, Presbyterian and Women and Children's Hospitals will receive allocations to be used primarily for demonstration purposes. The money is being made available to extend existing psychiatric and mental hygiene services. The funds are provided through the National Mental Hygiene Act for the development of local mental hygiene programs.

Accidents Lead Child Fatalities.—"Accidents are the greatest single menace to the lives of Illinois children at the present time," Dr. Roland R. Cross, state director of public health, declared recently in emphasizing the importance of the national child safety campaign now being conducted throughout the country. "The leading cause of death among children 1 to 15 years of age, accidents of one kind or another were responsible for 490 childhood fatalities in our state last year," Dr. Cross said. "This is almost one-third of the total number of deaths from all causes among these children." Motor vehicles were responsible for 171, or about 36 per cent, of accidental deaths among this age group. Accidents in the home resulted in 168 fatalities; accidents in public places took a toll of 149; and occupational accidents were responsible for two deaths. "Significant also is the fact that many of these accidents occurred among children under school age who are dependent upon their parents or other older persons for their safety," Dr. Cross said. Of the 490 child accident fatalities reported in Illinois last year, 202, or about 40 per cent, occurred among children between the ages of one and five. Dr. Cross also compared the child accident toll in Illinois with deaths resulting from communicable diseases. He pointed out that during 1947, when 490 children lost their lives accidentally, only 179 died of pneumonia and influenza. Only 56 died from tuberculosis and only 78 from all other communicable diseases combined. "Through immunizations and other advances in medical science deaths from the preventable diseases of childhood have been greatly reduced during recent years," Dr. Cross said. He urged that efforts now be intensified to bring about a comparable reduction in child accidents.

Work Starts on New Tuberculosis Hospital.—Governor Dwight H. Green has announced the release of $825,242 from the public works budget to the state department of public health, opening the way for immediate construction on a state tuberculosis sanitarium in Mt. Vernon.

This will be the first state hospital for the care of tuberculous patients. It is to be built under the provisions of the state-federal hospital construction program. The 65th General Assembly appropriated $850,000 for the hospital and $24,758 was previously released for the preparation of plans. The federal grant for the hospital is $446,692.

Ground-breaking ceremonies marking the actual start of the work were held at Mt. Vernon on October 15, it was announced recently by Dr. Roland R. Cross, state director of public health, who was to turn the first spadeful of earth.

John Wm. Chapman, secretary to Governor Green, served as master of ceremonies. Representatives of the Illinois State Medical Society, the Illinois Hospital Association, the Illinois Tuberculosis Association, members of the state advisory council on hospitals, county sanatorium boards, local health, welfare and tuberculosis associations, and the general public were invited to attend, Dr. Cross said. Music in connection with the ceremony was provided by the bands of the Mt. Vernon junior high school and the township high school. Radio station WMIX at Mt. Vernon broadcast the ceremony.

The committee on local arrangements, under the chairmanship of Lester Buford of Mt. Vernon, included: Harry Bishop, Mrs. Edna Casey, Clarence DeWitt, L. Ed. Dirks, Silas Echols, R. L. McConnell, Dr. W. G. Parker, Carl Schwein Furth, Fern Watson and Harold Watson.

Known as the Mt. Vernon state tuberculosis sanitarium, the new institution will be a part of the State's long-range program to provide adequate hospital facilities for the care of the tuberculous. To meet the shortage of sanitarium beds in Illinois, state and federal funds have also been provided for a second state tuberculosis hospital to be located in Chicago. It is expected that actual construction on the Chicago project will begin within the year.

With a capacity of 100 beds, the new sanitarium at Mt. Vernon is to be a two-story, fire-proof building erected adjacent to the proposed Good Samaritan Hospital. It will be modern in every respect, providing an out-patient department with complete X-ray equipment in addition to facilities for medical and surgical treatment, occupational therapy and rehabilitation. The new sanitarium will be operated under the direct supervision of the state department of public health.

"The lack of adequate sanitarium facilities for the care and treatment of tuberculosis patients has been one of the chief obstacles in the control of this disease," Dr. Cross said. I feel sure that the construction of this hospital at Mt. Vernon will contribute immeasurably to the final elimination of tuberculosis as a major public health problem in Illinois."

DEATHS

Cecil V. Bachelle, Chicago, who graduated at Rush Medical College in 1900, died September 21, aged 74.

Edward Berg, retired, Chicago, who graduated at Chicago Medical School in 1921, died September 9, aged 73.

Clarence J. Bertaut, Chicago, who graduated at St. Louis College of Physicians and Surgeons, St. Louis, in 1920, and Chicago Medical School in 1922, died suddenly September 14, aged 52.

Bert Ira Beverly, Oak Park, who graduated at Rush Medical College in 1924, died following a heart attack in his office, September 27, aged 54. He was assistant professor of pediatric psychiatry (Rush) of the University of Illinois College of Medicine, a Fellow of the American Academy of Pediatrics and a member of the Institute of Medicine of Chicago.

John A. Christenson, Chicago, who graduated at the University of Illinois College of Medicine in 1905, died September 13, aged 76. Was formerly on the teaching staff of the University of Illinois College of Medicine; on the medical staff of Augustana Hospital and was formerly president of the board of Augustana College, Rock Island.

Helen E. Collins, retired, Chicago, who graduated at Hering Medical College, Chicago, in 1900, died September 26, aged 78, of bronchopneumonia.

Michael F. J. Donovan, Chicago, who graduated at Bennett College of Eclectic Medicine and Surgery, Chicago, in 1915, died September 17, aged 63. He was a surgeon for the Rock Island Railroad and on the staff of St. George and Little Company of Mary Hospitals.

Harry R. Enlow, retired, Chicago, who graduated at Rush Medical College in 1907, died September 21, aged 69.

Erich R. Erlanger, Rockford, who graduated at the University of Heidelberg, Germany, in 1928, and came to Rockford in 1939, died August 9, aged 47.

Edgar W. Farthing, who retired from the active practice of medicine in 1907, and who graduated at Marion-Sims College of Medicine, St. Louis, died August 30, aged 82.

Charles R. Galloway, Libertyville, who graduated at Rush Medical College in 1892, died September 26, aged 77. He had practiced in Libertyville for 56 years.

Arthur R. Hansen, Chicago, who graduated at Chicago College of Medicine and Surgery in 1913, died September 11, aged 60. He was on the staff of Henrotin Hospital.

Ernest Monroe Hartfield, Freeport, who graduated at Reliance Medical College in 1909, died September 30, aged 67, following a long illness.

Matthew William James, Bensenville, who graduated at Reliance Medical College in 1911, died in Walther Memorial Hospital, August 25, aged 66.

Frank John Novak, Jr., Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1914, died at Riverside, Illinois, July 27, aged 60, of coronary sclerosis. He was a member of the American Larynogological, Rhinological and Otological Society and the American Otological Society.

Henry Benjamin Raman, retired, Springfield, who graduated at the University of Illinois College of Medicine in 1916, died September 2, aged 61, after a prolonged illness. He was a veteran of World War I.

Eugene A. Riccio, Chicago, who graduated at Marquette University School of Medicine, Milwaukee, in 1928, died October 3, aged 44, while making a call at a friend's home.

Percy J. Ross, Chicago, who graduated at the State University of Iowa College of Medicine in 1926, died September 28, aged 46, of a heart attack. He was associate otolaryngologist at St. Luke's Hospital and was a lieutenant colonel in World War II.

Straut Watson Shurtz, retired, Champaign, who graduated at Rush Medical College in 1893, died September 24, aged 83, at Burnham City Hospital. He had practiced medicine in Champaign County over fifty years and was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Orris Martin Thompson, Bloomington, who graduated at Northwestern University Medical School in 1906, died suddenly September 2, aged 70, of a heart attack. He was a past president of the McLean County Medical Society and the LeRoy Kiwanis Club and a veteran of World War I.

Oliver Benjamin Winkler, Lebanon, who graduated at St. Louis University School of Medicine in 1927, was found dead in his bed, September 9, aged 47. He had practiced medicine in Lebanon more than twenty years.

"FOR THE COMMON GOOD"

Lectures Arranged Through the Educational Committee, Illinois State Medical Society; Charles P. Blair, Monmouth, Chairman; Warren W. Furey, Chicago, Vice Chairman:

Edward C. Turner, Savanna, Kiwanis Club of Geneseo, October 5, Socialized Medicine.

Sydney B. Mannel, Chicago, Grover Cleveland PTA, October 20, in Chicago, Good Health and Behavior.

Roy Kegerreis, Elmhurst, Somonauk PTA in Somonauk, October 21, The Newer Things in Medicine.

Joseph Bertucci, Chicago, Lafayette School PTA, November 9, in Chicago, Children's Ailments.

Harry Leichenger, Chicago, Barry School PTA in Chicago, Novermber 9, on Child Health.

Henry Fineberg, Chicago, Lincoln School PTA in Chicago Heights, November 10, on Behavior and Mental Hygiene.

Mr. John L. Bach, director of press relations, AMA, North Central Medical Association, in Princeton, November 11, Pickpocket Medicine.

Belle Korman, Chicago, Hermosa Woman's Club in Chicago, December 3, Know Your Heart.

Mr. John W. Neal, Chicago, Illinois State Veterinary Medical Association in Springfield, January 27, Socialized Medicine: Threshold of the Welfare State.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman; Louis R. Limarzi, Chicago, Vice Chairman:

Lindon Seed, Chicago, Kane County Medical Society in Aurora, October 20, Hyperthyroidism in the Aged.

Burton C. Kilbourne, Chicago, McHenry County Medical Society at Giesta, Cyrstal Lake, October 21, on Fractures of the Wrist and Forearm.

Harry M. Hedge, Chicago, Fulton County Medical Society in Canton, October 29, on Common Diseases of the Skin, illustrated.

Danely Slaughter, Chicago, Champaign County Medical Society in Champaign, November 11, Present Day Advances in the Treatment of Cancer, including both surgery and chemotherapy.

Alfred J. Cone, St. Louis, Fulton County Medical Society, in Canton, November 19, Diseases of the Esophagus, including Difficulties in Swallowing Caused by Crico-pharyngeal Spasm; Diverticulum; Carcinoma; Segmental Spasm and So-called Cardiaspasm.

Michael H. Streicher, Chicago, La Salle County Medical Society, in La Salle, December 9, on Diagnosis and Management of Various Types of Diarrheas.

Eric Oldberg, Chicago, Champaign County Medical Society in Champaign, December 9, on Management of Head Injuries.

F. Steigmann, Chicago. Effingham County Medical Society in Effingham, December 16, Diagnosis and Treatment of Jaundice and Liver Disease.

H. L. Baker, Chicago, Will-Grundy County Medical Society in Joliet, January 13, on Differential Diagnosis of the Acute Abdomen.

Conference Arranged for Monmouth.—The third postgraduate conference in the series of twelve planned by the Postgraduate Education Committee of the Illinois State Medical Society was held in Monmouth, October 28. Dr. Charles P. Blair, Monmouth, Councilor for the Fourth Councilor District, presided. The session opened at the Elks Club with a complimentary luncheon by the Warren County Medical Society. The following Chicago speakers participated:

Henry Poncher, Pediatric Therapeutics.

Arkell M. Vaughn, vagus Nerve Resection in the Treatment of Peptic Ulcer.

Theodore Van Dellen, Rheumatic Heart Disease.

Eugene A. Hamilton, Fractures.

Percy E. Hopkins, President of the Illinois State Medical Society, Acute Abdominal Emergencies.

A round table discussion concluded the afternoon's program. At the dinner session, Dr. Hopkins gave a short discussion on "Prepayment Medical and Surgical Care" and Dr. Harry M. Hedge, the principal evening paper on "Birthmarks." The Fourth Councilor District includes the counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark and Warren. Robert S. Berghoff is Chairman of the Postgraduate Education Committee and George A. Hellmuth, Vice Chairman.

"It's Your Life".—It's Your Life, a new 15-minute documentary program dealing with problems of personal health, was inaugurated **October 18,** at 11:15 a.m. CST over Station WMAQ. It will be heard Mondays through Fridays at the same time thereafter, presented as a public service by Johnson & Johnson, manufacturers of medical supplies.

The series will be written and directed by Ben Park, producer of the award-winning "Report Uncensored" which dealt with Chicago's delinquency, prisoner-rehabilitation and housing problems.

It's Your Life will tell informative stories of better life and better living through authentic tape-recorded interviews made with hundreds of anonymous Chicagoans who have experienced the problems of health — from child-care to cancer, from accidents to alcoholism. About 300 of Chicago's health and

welfare agencies will be directly involved with the planning and production of the programs.

It's Your Life is produced and leased by the Chicago Industrial Health Association. Organized in January, 1948, the Association secured the services of Percy Shostac, formerly director of the Fort Greene Industrial Health Association of Brooklyn, to head up its unique program for Chicago. It was Shostac's idea that a popular and informative radio program about vital health problems could find a sponsor interested in institutional public service. Park was signed by the association in April to carry this idea forward.

The new radio series will spearhead an extension educational program by the association, which also is planning a monthly magazine for industrial workers, and active cooperation with medical departments in Chicago firms.

Working with the 30 member agencies of the Chicago Industrial Health Association and with many more interested groups and individuals, Park, together with Schostac and Dr. Frederick Slobe, chairman of the board of CIHA, formulated the basic plans for a comprehensive radio series on health.

From the beginning it was recognized that concern about personal and family health is the number one anxiety of most people. Prior to this time, the obvious appeal inherent in the real problems of health never had been effectively utilized to interest vast radio audiences in a popular program on the subject. It was decided, therefore, to work out a format which would invest this new program with all of the suspenceful, starkly dramatic, and unusual human interest which those in the medical and social work fields always have known.

Authentic tape-recordings with real people provide the key to answering this need. The tape recordings bring to the listener the unrehearsed and authentic stories of actual people taken in their own surroundings where they work or live.

Several agencies, among them the American Cancer Society, American Medical Association, Council on Industrial Health, Chicago Committee on Alcoholism, Chicago Medical Society, Council of Social Agencies Health Division, Illinois Social Hygiene League, Michael Reese Hospital, Red Cross, the Chicago Tuberculosis Institute and many others, worked directly with Park in the preparation of the two presentation recordings which were used to demonstrate the program's usefulness to the medical profession.

Absolute accuracy of medical information heard on the program and correctness of its psychological impact will be assured by a planning and checking system that operates from six weeks before a program goes on the air right up until broadcast time. Original plans for the broadcasts will be outlined with the aid of CIHA's radio advisory committee, composed of some of Chicago's outstanding medical authorities. Later, when broadcasts are ready for the air, they will be completely reviewed by this committee and by the Educational Committee of the Illinois State Medical Society. Contacts for interviews will be established through qualified medical and medical social work personnel.

Several doctors and medical information authorities have heard the sample recordings of the programs and have given their expressed approval. Among these are Dr. W. W. Bauer, Dr. Lowell Coggeshall, Louis De Boer, Ellwood Douglass, Dr. Morris Fishbein, Dr. Warren W. Furey, Dr. Edward C. Holmblad, Dr. James H. Hutton, Dr. Andrew C. Ivy, Dr. Earl Kleinschmidt, Dr. Edwin Levine, E. P. Lichty, Kenneth Morse, Miss Mary E. Murphy, Dr. Carl Peterson, Dr. Edward A. Piszczek, Dr. John A. Rogers, Alexander Ropchan and Dr. Bertha Shafer.

Assisting in the production of It's Your Life is Don Herbert, familiar to Chicago's social agencies as the originator, narrator and producer of "Feature Story," popular Community Fund presentation formerly heard regularly over Station WJJD, Chicago. Herbert has left his position as radio director of the Community Fund to take part in the new project.

Production of It's Your Life on WMAQ is believed to represent the first occasion in radio annals where a program produced by a voluntary agency with a primary public service objective has been underwritten by a commercial sponsor. Young and Rubicam, Inc. is the advertising agency.

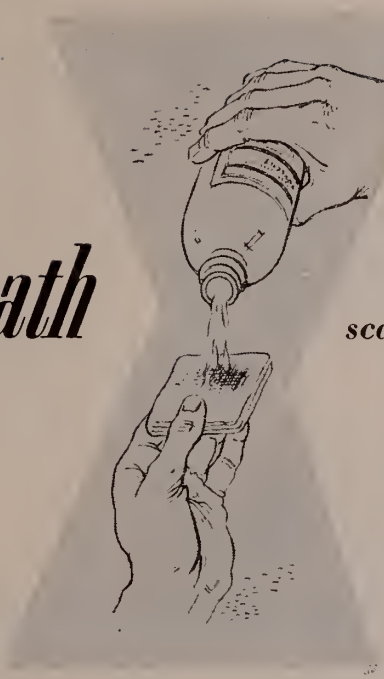
Dog Hero Honored on WBKB.— A special honor was televised, Friday, October 1, when Caesar, dog hero, was presented with a medal by the National Society for Medical Research. The presentation was made by Dr. Andrew C. Ivy, Vice President, University of Illinois, in charge of the Chicago Professional Colleges, and Secretary-Treasurer of the National Society for Medical Research.

The feature was a part of the Health Education Series of the American Medical Association on WBKB and was developed in cooperation with the Educational Committee of the Illinois State Medical Society and the National Society for Medical Research.

The medal marks the significant contribution of Caesar to the advancement of medical research. Seventy-six children in the Chicago area owe their lives to Caesar. Once known as "blue babies" these children, through a special operation performed on the vessels of the heart, are now leading a normal life. Caesar was the dog hero who figured in the original research at Children's Memorial Hospital, Chicago. Appearing with Caesar and Dr. Ivy on the program will be two of the former blue babies.

Dr. Ivy is noted for his research as a physiologist. He has made numerous contributions to the scientific literature, the most recent of which is his work on peptic ulcer and the ethics of human experimentation. This last was based on his experiences during the Nuremburg trials exposing the use by Nazi doctors of human beings as guinea pigs.

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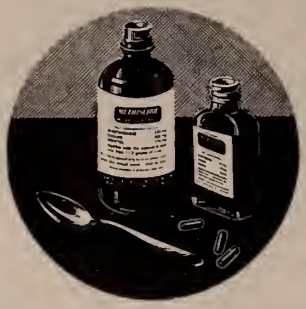
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* Wooldridge, W. E.: The Gamma Isomer of Hexachlorocyclohexane in the Treatment of Scabies, J. Invest. Dermat. *10*:363 (May) 1948.

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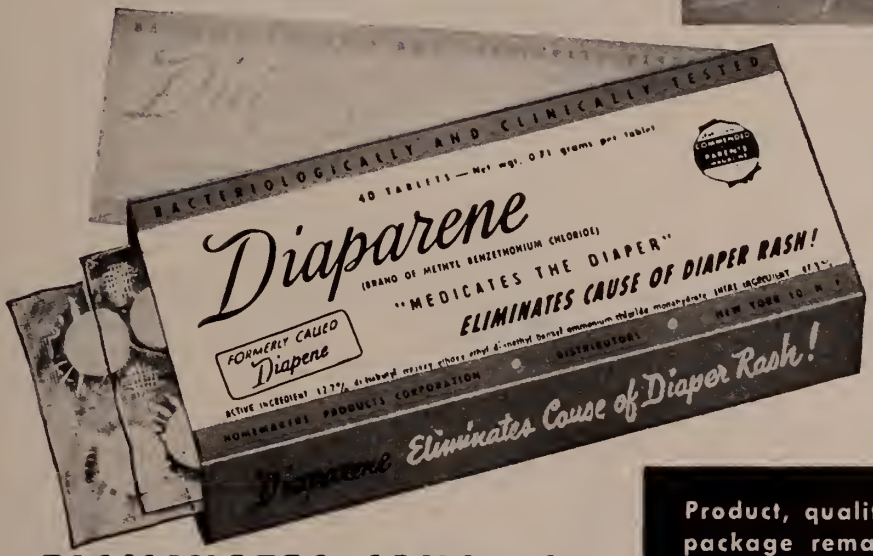
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- 1. Cooke, J. V.: Brennemann Proctice of Ped. 4: Chapter 41, 1945.
- 2. Bensan, R. A. et al: J. Ped. 31:369-754, 1947.
- 3. Sullivan, N.: Int'l Congress of Ped., Mt. Sinai Hospital, New York, 1947.

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PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER



REITER'S DISEASE; REPORT OF FIVE CASES INCLUDING TWO SUCCESSFULLY TREATED WITH HYPERTHERMIA

Edward W. Lowman and Robert J. Boucek. ANNALS OF INTERNAL MEDICINE. Vol. 28 (O.S., Vol. XXXII). Page 1075. June 1948.

Reports of the triad of urethritis, conjunctivitis, and arthritis (so-called Reiter's disease) have appeared more and more frequently in the literature since its initial presentation by Reiter in 1916. This represents in all probability not an increase in the incidence of the condition but a more frequent consideration of the triad in differential diagnosis. On the other hand, however, there have been few reports of successful therapy, and the general tone by inference or conclusion has been that there is no specific treatment for the disease. In this series, five cases were seen, two of which were treated with hyperthermia and penicillin.

1. Five cases of Reiter's disease have been presented. Four are typical cases with classical triad of symptoms while the fifth probably represents an incomplete syndrome without the conjunctivitis.

2. Two of the cases presenting the complete triad responded to treatment with artificial hyperthermia and penicillin and promptly went into remission. These cases had been chronically ill for six and seven months respectively. Follow-up examinations after four and six months respectively showed no recurrence.

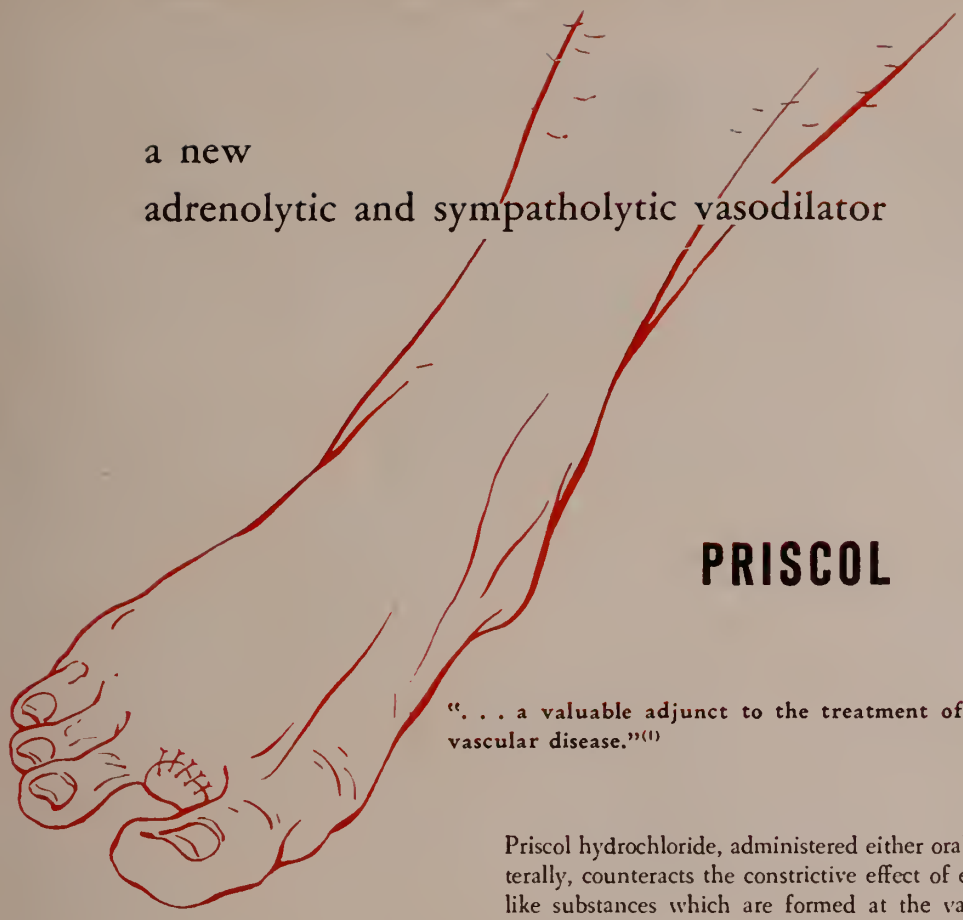
THE SHOULDER-HAND SYNDROME IN REFLEX DYSTROPHY OF THE UPPER EXTREMITY

Otto Steinbrocker, Norman Spitzer and H. Harold Friedman. ANNALS OF INTERNAL MEDICINE. Vol. 29 (O.S. Vol. XXXII). Page 22. July 1948.

A variety of seemingly unrelated clinical disorders, usually considered distinct entities, have been described in the surgical and medical literature for many years. These conditions include causalgia, Sudeck's atrophy (post-traumatic osteoporosis), painful disability of the shoulder following coronary occlusion, post-infarctional sclerodactylia, palmar and digical contractures as well as Dupuytren's contracture, the swollen atrophic hand associated with cervical osteoarthritis, certain changes in the paretic limbs of hemiplegics, and a number of others. In this group belongs the idiopathic shoulder-hand syndrome. It is becoming increasingly apparent that, although the etiology of these various syndromes may be different, many of the clinical features, and probably the neurovascular mech-

(*Continued on page* 46)

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adrenolytic and sympatholytic vasodilator



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". . . a valuable adjunct to the treatment of peripheral vascular disease."[1]

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Patients should be closely observed until optimal dosage is established since paradoxical effects or orthostatic hypotension may occur.

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10 cc. Multiple-dose Vials, each cc. containing 25 mg.

1. Grimson, K. S., Marzoni, F. A., Reardon, M. J., and Hendrix, J. P.: *Surg.*, 23:728, 1948.

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anisms underlying their development, are very similar, if not identical.

Orthopedic and Physio-Therapeutic Measures

Immobilization of the affected parts in conjunction with the various modalities of physical therapy — heat in all forms, heliotherapy and massage have been utilized extensively. These measures, however, apart from giving temporary palliation, seem to exert little influence on the course of the disease. Oppenheimer, on the other hand, employed short-wave diathermy to the cervical spine and in six of seven cases with swelling and atrophy of the hand secondary to cervical osteoarthritis he reported recovery. Our results with this form of treatment have not been impressive.

Manipulative procedures have been widely condemned. Manipulation of the shoulder, especially, in these cases is apt to be based on a misdiagnosis of bursitis, fibrositis and, possibly, scalenus anticus syndrome. The shoulder discomfort and disability frequently are regarded as symptoms complicating, or unrelated to, the hand signs. According to our experience such deductions usually represent a failure to correlate the salient features of the shoulder-hand syndrome.

THE USE OF PHYSICAL AGENTS IN GENERAL PRACTICE

Walter J. Lee, M.D., Richmond, Virginia. In SOUTHERN MEDICAL JOURNAL. July 1948, Volume 41, No. 7, Page 655.

The active cooperation of the arthritic patient is essential for obtaining satisfactory results in mobilizing joints and maintaining good muscle tone. It is my opinion that in the early acute stage complete rest of the joint is indicated. Proper positioning and splinting are necessary during this early phase, and static of muscle-setting exercises only are used. Watkins says that as the inflammatory process subsides carefully graded active exercises may be initiated; at first consisting of active assisted motions, and later of voluntary exercise. Resistive exercises are rarely indicated because of the tendency toward subluxation. As the process becomes chronic or a remission occurs, active resistive exercises can be instituted. These exercises are to be carefully graded and purposefully being directed primarily toward gait and posture training. For developing strength, coordination, and skill in the upper extremities occupational therapy is utilized. Mental as well as physical function is stimulated by this method. Occupational therapy can consist of anything, from weaving a rug to driving a nail provided the exercise performed is interesting, purposeful, and directed toward improvement of function. Occupational therapy may also take the form of pre-vocational training as a part of adequate re-habilitation.

Rheumatoid spondylitis provides a condition to illustrate the value of special exercises in the prevention and treatment of disability. Deep breathing and postural exercises are a valuable adjunct when combined with x-ray and other recognized procedures.

Since rheumatoid arthritis tends toward chronicity, physical measures that can be utilized in the home each day are to be recommended. Treusch and Krusen reported a survey of home physical therapy in 229 cases of arthritis, and found that 93 per cent of the patients followed the instructions for home therapy and 65 per cent continued them for three months or longer. They observed that patients with more than one course of instruction were more likely to carry on. Four-fifths of the patients were definitely benefited, and two-fifths were enthusiastic over the regime. How physical agents may be used in general practice has been illustrated in the treatment of arthritis.

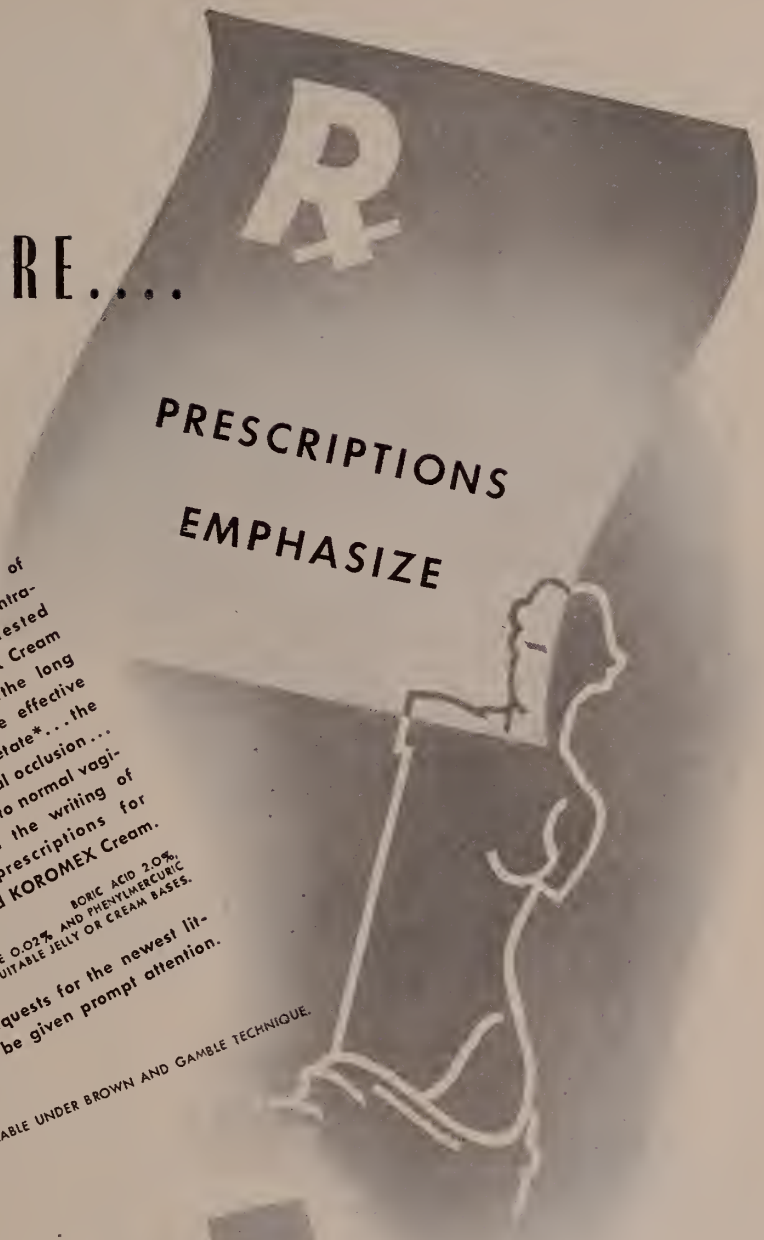
SOME POINTS IN MANAGEMENT OF INFANTILE CEREBRAL PALSEY

By John H. Crosland, M.R.C.S., L.R.C.P. PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE. Vol. XLI. Page 406. June 1948.

The earlier treatment can commence the better, and an age of one year is certainly not too young. There are obvious risks of maldiagnosis in starting at this age, and it is not easy to determine whether the child be intelligent or not, but there is one very great advantage in that the child does not develop bad movement patterns in the endeavor to overcome his handicap himself, and further the right environment can be ensured. In the older child these bad habits of

(*Continued on page* 48)

MORE AND MORE....



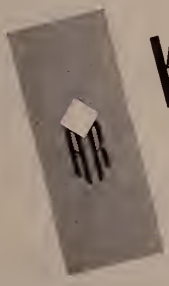
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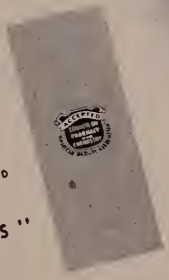
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movement superimposed upon the original handicap are very difficult to deal with and make the best results almost impossible of attainment.

Where there is not gross athetoid movement, the child should be encouraged to roll and kick on the floor, and he may be allowed to crawl, but he should not be allowed to stand or walk until his reablement program is well advanced.

As treatment programs are long and may continue for months at a time, it is most important that the child's interest in his treatment should be aroused and maintained. To this end his rehabilitation must be made as attractive as possible, and one good plan is to teach him exercises, etc., to the sound of an easily learned tune preferably sung to him in order that he may get the sense of the words as well.

Due to the natural enthusiasm of teachers and therapists there is danger of overworking the child and overtaxing his powers of concentration. Programs must therefore be carefully worked out with this in mind, and adequate rest periods provided.

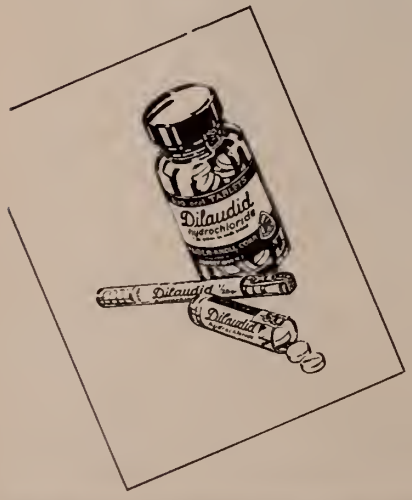
Passing to the spastic type of cerebral palsy, it will be found that these children are often extremely fearful. They must therefore at all times feel perfectly secure. Treatment tables must be wide enough to give them this feeling of security, and they must be handled firmly and competently. At the same time a scheme of exercises is made out for the re-education of their limb muscles, and when as much improvement in pelvic control as possible has been obtained they can pass to practice in sitting unsupported, kneeling, standing, and finally walking. It is always useful to get as much aid from gravity as possible by posturing the child in his exercises. Thus he may be placed head downwards on a tilted table where the pectoral muscles are spastic. Again, where the dorsiflexors of the foot are weak, as they often are, he may be placed on his abdomen with his legs at right angles to the

(Continued on page 50)

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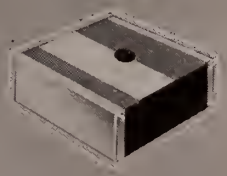
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1. Walter, R. I.; Goldberger, M. A.; and Lapid, L. S.; New York State J. Med. 48: 1159 (May 15) 1948.

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table. In the child with athetisis the key-note of management is relaxation. If he can be taught to relax efficiently, he can lose a great deal of his unwanted movements. It is very important that these children should have really adequate rest periods because of the greatly increased amount of energy consumed by this uncontrolled movement. When relaxation has been achieved as well as may be, he must be taught new movements of the affected limbs which are purposive movements under his own volitional control.

Occupational therapy is an important part of the management of most types of cerebral palsy. It has, of course, little part where the arms are unaffected. Its main sphere is to teach the child to carry over into every day actions what has been taught him by the physical therapist. That is to say, he is taught to feed himself, and to dress himself, and this is carried out by practice with various feeding aids, such as drinking straws, special plates, spoons, etc. In learning to dress, the child will first practice buttoning, lacing, etc., on models held immovably in frames. He is also taught the movements of writing, and, if it is thought he will not be able to achieve this legibly, he is taught to use a typewriter. While the occupational therapist must see that the rest of athetoid child is being taught these skills the his body is maintained in the relaxed position.

ELECTRIC CONVULSIVE THERAPY IN MENTAL DISORDERS ASSOCIATED WITH CHILDBEARING

David A. Boyd, Jr., M.D., Indianapolis, Ind. and Dewitt W. Brown, Indianapolis, Ind. In THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION, August, 1948, Volume 45, Page 573.

Electro-convulsive therapy has had sufficient clinical trial to establish its value and comparative safety in mental disorders associated with childbearing. Its utilization should be considered seriously in all cases of manic-depressive and schizophrenic disorders of the gestational and puerperal periods. The decision of whether or not it is to be instituted should be based on the

(Continued on page 54)





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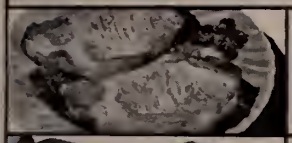
* Campbell, P. A.: Diagnosis and Treatment of External Otitis, Illinois M. J., *93*:98-102 (Feb.) 1948.

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 BEEF	EXCELLENT	FAIR	EXCELLENT	EXCELLENT	EXCELLENT
 LAMB	EXCELLENT	FAIR	GOOD	EXCELLENT	EXCELLENT
 VEAL	EXCELLENT	GOOD	GOOD	EXCELLENT	EXCELLENT
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Physical Medicine (Continued)

total treatment needs of the patient, and the greater emphasis should be placed on the psychiatric indications rather than on the physical condition of the puerperal status.

The early utilization of electroshock treatment in puerperal manic-depressive and schizophrenic psychoses will shorten the duration of illness, reduce the medical and nursing problems and produce a better rate of recovery than any of the previous forms of treatment. In gestational psychoses it often makes it possible to carry the pregnancy to term and simultaneously improve the physical condition of the mother. The course of therapy should be instituted as soon as the diagnosis can be established inasmuch as the dangers of chronic mental invalidism are fully as great as the physical hazards.

TREATMENT OF PERIPHERAL NERVE INJURIES

Rear Admiral Winchell McK. Craig, M.C., U.S.N.R.
In THE MILITARY SURGEON. July, 1948, Vol. 103, No. 1, Page 1.

The surgical treatment of peripheral nerve injuries is only one small part in the entire treatment. Injury to a peripheral nerve affects the extremity which that nerve supplies, and an extremity which has been denervated is obviously incapable of performing normal activities. Not only is the muscular activity interfered with, but the vascular and trophic phases are so altered that there is discomfort and disability.

A greater appreciation of splintage has been acquired as the evils of immobile casts and lack of exercise of muscles and joints involved was indelibly impressed upon the minds of the surgeons and the physiatrists who attempted final rehabilitation. Splinting applied for support and allowing movements of adjacent joints is of value. Passive motion and gentle massage maintain better metabolism of the muscles and create a more receptive condition for reinnervation.

It has been proved that an evaluation of return of function after injuries to peripheral nerves cannot be reached until several years have elapsed. Not only must there be a complete regeneration of the nerve but there must be an adjustment period during which the muscles of finer co-ordination must be re-educated.

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BOOK REVIEWS



GENERAL ENDOCRINOLOGY, by C. Donnell Turner, Ph.D., Associate Professor of Zoology at Northwestern University, W. B. Saunders Company, Philadelphia, 1948. Illustrated. 604 pages.

The author states that the subject is approached from an experimental rather than a clinical point of view, and this is correct. The subject matter is divided into thirteen chapters which deal with the structure and function of the various endocrine glands. It should be of interest not only to students for whom it was written but also to clinical endocrinologists, particularly those who got out of school more than twenty years ago. As a matter of fact, it should be interesting reading for any practitioner of medicine.

J. H. H.

CLINICAL NEURO-OPHTHALMOLOGY by Frank B. Walsh, M.D., F.R.C.S. (Ed.), Associate Professor of Ophthalmology, The Johns Hopkins University. Baltimore, Md., The Williams & Wilkins Company. Published 1947. Price $15.00.

This book of 1532 pages is a highly informative publication concerning ophthalmic diagnosis. The author has the firm conviction that "ophthalmologic diagnosis in other than 'pure' ophthalmologic cases must be based on a general knowledge of disease processes and detailed knowledge regarding the ophthalmologic features of disease."

Doctor Walsh has prepared a comprehensive work on neuro-ophthalmologic diagnosis utilizing 615 illustrations to implement the pertinent anatomic, physiologic, neurologic and other basic information. Many case reports are presented to exemplify what is probably every problem in neuro-ophthalmological differential diagnosis. References are listed at the end of nearly each one of the many sections. Where applicable appropriate therapy is given, although often briefly.

The staff of Wilmer Institute and the staffs of other departments in The Johns Hopkins University are credited with help and advice in the preparation of this intensely interesting volume. Particularly mentioned are Doctors Ford, Dandy and Woods.

Internists, ophthalmologists, neurologists and general practitioners will find this textbook a valuable diagnostic guide in clinical neuro-ophthalmology.

L. P. A. S.

THE ACUTE BACTERIAL DISEASES: Their Diagnosis and Treatment. By Harry F. Dowling, M.D., F.A.C.P. Clinical Professor of Medicine, George Washington University. Chief, George Washington Medical Division, Gallinger Municipal Hospital. With the Collaboration of Lewis K. Sweet, M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and Harold L. Hirsh, M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. 465 pages with 55 figures. 1948. W. B. Saunders Co., Philadelphia. $6.50.

According to the preface this book is intended to be a practical guide to acute bacterial diseases for physicians and medical students. It opens with a short section on general considerations of diagnosis and treat-

(*Continued on page* 58)

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1. Paul, W. D., and Montgomery, A. E.: J. Iowa State M. Soc. 38: 237 (June) 1948.

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Book Reviews (Continued)

ment of these conditions, and the remainder of the book contains a discussion of individual diseases.

Each disease is well covered from the practical standpoint. The language is clear and concise. The value of the book is not impaired because of a few questionable minor statements, such as the implication on page 23 that contaminated instruments may be sterilized by wiping with 70% alcohol; and if streptomycin is neutralized by isotonic sodium chloride solution as stated on page 95, advocation of its use in this solution on page 96 is questionable. In general this is a most satisfactory book. The charts are welcome and the few color plates are well reproduced.

J. C. S.

PRACTICAL BACTERIOLOGY, HEMATOLOGY, AND PARASITOLOGY. By E. R. Stitt, M.D., Ph.M., Sc. D., LL.D., Rear Admiral, Medical Corps, Surgeon General, U. S. N., Ret.; Paul W. Clough, M.D., Physician-in-Charge of Diagnostic Clinic, Johns Hopkins Hospital; and Sara E. Branham, M.D., Ph.D., Sc.D., Senior Bacteriologist, National Institute of Health. The Blakiston Company, Philadelphia. Tenth Edition. 991 pages, 765 illustrations. 1948. $10.00.

This is the tenth edition of this minor classic on practical laboratory procedures. The first edition appeared in 1909 and the last previous edition was in 1938 so that extensive revisions and additions were necessary. These have been made by various collaborators connected with the National Institute of Health and the U. S. Naval Medical School. As before, the book emphasizes practical details of technic with guidance as to methods and aid in interpretation.

A concise description of symptomatology is included with most diseases so that each condition is approached from the clinical as well as the laboratory standpoint. About equal consideration is given to tropical diseases and those of temperate climates as the book was written with those in remote or tropical laboratories in mind. This book remains practical, readable and full of accessible information and explicit instruction. Recommended.

J. C. S.

"CANCER MANUAL" published by the Cancer Committee of the Iowa State Medical Society, Athens Press, Iowa City, Iowa, Second Edition, 1948.

This manual has been prepared by the Cancer Committee of the Iowa State Medical Society, primarily for the general practitioner who, in general, is the first physician to see the patient. The first two sections entitled "General Considerations", and "The Cancer Problem and the Family Doctor" deal with subjects such as incidence, education of the public, professional education, methods of treatment and importance of early diagnosis. The importance of early diagnosis, type of

(*Continued on page* 60)



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Often perverted food attitudes and abnormal outlooks regarding foods and nutrition interfere with adequacy in dietary intake or are responsible for nutritionally improper eating habits. Accordingly, excessive amounts of foods one-sided in nutrient content are consumed, or more desirable foods are avoided, to the detriment of the nutritional health.

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IRON	12.0 mg.	COPPER	0.50 mg.

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Book Reviews (Continued)

tumor, and influence of presence or absence of metastases on prognosis, are properly stressed. Education of the public to the importance of going early to physicians for examination, and the great responsibility of the physician in not overlooking cancer are emphasized.

With the exception of a short section on Radiation Therapy, the remainder of the manual is devoted to a discussion of cancer in the various organs or regions of the body. In each section, the type of malignancy encountered, the manifestations (early and late) produced by the tumor, differential diagnosis and methods of treatment are discussed; prognosis, including figures on the expected 5 year cure rates are presented for the more important tumors. At the end of the manual is a splendid bibliography, which is divided according to organs involved; the references chosen are recent, and in general represent important articles in that field.

The entire manual is written in a clear concise manner. By intention and necessity it is brief, but contains a remarkably large amount of valuable data for the physician who may be consulted by patients with various types of complaints, many of which may be caused by tumors.

There are remarkably few errors in the manual. One of the few places where the reviewer found any statements which might be considered correctible was in the discussion of treatment of carcinoma of the rectum. Although their statement may have been true 10 or 15 years ago, in the reviewer's opinion, the authors have been too critical of the one-stage Miles operation, and give too much praise for the two-stage operations of Rankin and Lahey.

This manual contains so much valuable information regarding the various features of malignant disease that it should be possessed and used by every physician caring for patients with varied complaints as encountered in general practice.

W. H. C.

IDENTIFICATION OF TUMORS. N. Chandler Foot, M.D., Professor of Surgical Pathology, Cornell University Medical College; Surgical Pathologist to New York Hospital. J. B. Lippincott Company, Philadelphia. 397 pages. 241 illustrations. 1948. $6.00.

As stated in the preface, Doctor Foot's latest book is intended to serve as a guide to the identification of tumors, rather in the manner of the pocket guides available to the amateur naturalist. It is meant to supplement one of the more detailed texts on this subject. The book is well fitted to this purpose, containing short discussions of all the common tumors and most of the rare ones, and supplemented by many excellent photomicrographs. The style is clear and concise as is usual with this author, and if the book is a trifle didactic, this cannot be objected to in a work of this type. It should be useful for those interested in a ready reference to tumors.

J. C. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

A Textbook of General Physiology: By Philip H. Mitchell, Ph.D., Robert P. Brown, Professor of Biology, Brown University, McGraw-Hill Book Company, Inc., New York, 1948. Price $7.50.

A. N. A. Public Relations Workshop; Publisher: American Nurses' Association, New York, N. Y. 32 pages; 39 illustrations; Price $2.50.

Detailed Atlas of the Head and Neck: Raymond C. Truex, M.S., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University, and Carl E. Kellner, Artist, Department of Anatomy, College of Physicians and Surgeons, Columbia University. Oxford University Press, New York, 1948. Price $15.00.

Your Baby. The Complete Baby Book for Mothers and Fathers. Gladys Denny Shultz, Contributing Editor, Ladies' Home Journal. Lee Forrest Hill, M.D., Former President, American Academy of Pediatrics. Photography by Joseph Di Pietro. Line Drawings by Reisie Lonette. Doubleday & Company, Inc., Garden City, N. Y., 1948. Price $3.50.

A Method of Anatomy: Descriptive and Deductive: By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.) Professor of Anatomy in the University of Toronto. Fourth Edition. The Williams and Wilkins Company, Baltimore, 1948. Price $7.00.

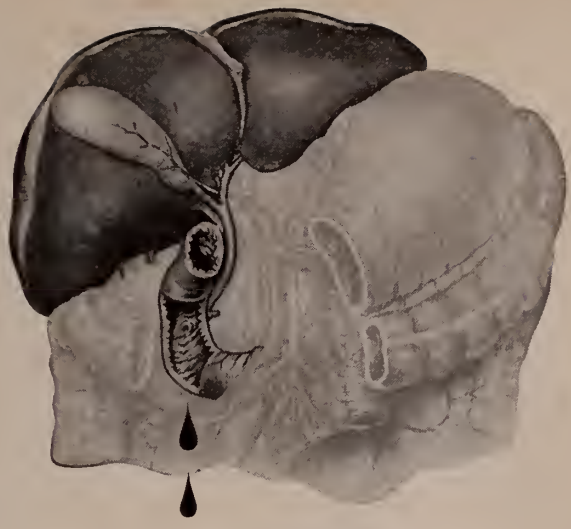
Bailey's Text-book of Histology: Revised by Philip E. Smith, Ph.D., Professor of Anatomy, College of Physicians and Surgeons, Columbia University, and Wilfred M. Copenhaver, Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Twelfth Edition. The Williams & Wilkins Company, Baltimore, 1948. Price $7.00.

Clinical Roentgenology of the Digestive Tract: By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, University of Maryland; Associate in Gastroenterology, Mercy Hospital; Consulting Roentgenologist, Sinai Hospital. Third Edition. The Williams & Wilkins Company, Baltimore, 1948. Price $8.00.

Fractures and Dislocations for Practitioners: By Edwin O. Geckeler, M.D., Fellow of the American College of Surgeons; Fellow of the American Academy of Orthopaedic Surgeons; Fellow of the American Association for the Surgery of Trauma; Diplomate of the American Board of Orthopaedic Surgery. Fourth Edition. The Williams & Wilkins Company, Baltimore, 1948. Price $5.00.

A Treatise on Contemporary Religious Jurisprudence: By I. H. Rubenstein of the Illinois Bar. The Waldain Press, Chicago, 1948. Price $2.50. (P. O. Box 97, Chicago 90, Illinois)

Pediatric Anesthesia: M. Digby Leigh, M.D., Di-



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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Classified Advertisements 68

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American Meat Institute, Chicago 53
Coca Cola, Atlanta, Ga.
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover
National Confectioner's Assn., Chicago 2 42
Wander Company, 360 N. Michigan Ave., Chicago 59

FINANCIAL AND INSURANCE

Medical Protective Co., Fort Wayne, Ind. 26
Physician Casualty Co., Omaha, Neb. 60

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 29
Ames Co., Inc., Elkhart, Ind. 61
The Arlington Chemical Co., Yonkers, N. Y. 27
Armour Laboratories, Chicago 9, Ill.
Ayerst, McKenna & Harrison Ltd., New York 16 12
Barlow-Maney Laboratories, Inc., Cedar Rapids, Iowa ..
Bilhuber Knoll Corp., Orange, N. J. 48
Borcherdt Malt Extract Co., Chicago 12, Ill.
Bristol Laboratories, Inc., Syracuse 1, N. Y. 13
Bristol-Meyers Co., New York 38
The Central Pharmacal Co., Seymour, Ind. 58
Ciba Company, Summit, N. J. 4, 31, 45
Commercial Solvents Corp., Terre Haute, Ind. .. 6, 32, 41
Doho Chemical Corp., New York 13, N. Y.
Endo Products Inc., Richmond Hill 18, N. Y.
C. B. Fleet Co., Inc., Lynchburg, Va. 28
Gold Pharmacal Co., New York 67
Hoffman-LaRoche, Inc., Nutley, N. J. 11
Holland-Rantos Co., Inc., 551 Fifth Ave., New York ...47
Homemakers Products Corp., New York 10, N. Y. 43
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 54
Interchemical Corp., Union, N. J.
International Pharmaceutical Corp., Boston 16
International Vitamin Corp., 50 E. 42nd St., New York City 55
Irwin, Neisler & Co., Decatur, Ill.
E. E. Kunze, Inc., Milwaukee 4 21
Lanteen Medical Laboratories, Chicago 10 16
Lily, Eli & Co., Indianapolis, Ind. 35, 36, 37
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Medicine of the Year, Chicago 12 24
Merck & Co, Rahway, N. J. 25
Morris, Philip & Co., 119 Fifth Ave., New York
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Parke, Davis & Co., Detroit, Mich. 9
Plastishield, Inc., Minneapolis
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Rexall Drug Co., Los Angeles
Reynolds & Co., R. J., Winston-Salem, N. C. 18
Roche-Organon, Inc., Nutley, N. J. 34
J. B. Roerig & Co., 536 Lake Shore Drive, Chicago
Sandoz Pharmaceuticals, New York 14 50
Schenley Laboratories, Inc., N. Y. 1, N. Y. 8, 49
Schering Corp., Bloomfield, N. J. 17
Schmid, Julius, Inc., 423 W. 55th St., New York City ..
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, 11 Canal St., Chicago 23
Smith, Kline & French, Philadelphia 3, 22, 33, 39, 57
E. R. Squibb & Co. 15
The Tarbonis Co., Cleveland 3, Ohio
Upjohn Co., Kalamazoo, Mich.
U. S. Vitamin Corp., New York 17 40
Walker Vitamin Products, Inc., New York
Wm. R. Warner & Co., 113 W. 18th St., New York ... 30
Whittaker Laboratories, Inc., New York City 5
White Laboratories, Inc. 19, 20, 51, 52
Winthrop Stearns Co., 70 Varick St., New York 10
Wyeth Incorporated 14
Zemmer Co., Pittsburgh, Pa. 68

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 63
Costeff Sanatorium, Peoria, Ill. 66
Douglas Park Hospital, Chicago 23 63
Edward Sanatorium, Naperville, Ill. 64
Michell Farm, Peoria 64
Milwaukee Sanitarium, Wauwatosa, Wis. ... Back Cover
Norbury Sanatorium, Jacksonville, Ill. 65
North Shore Health Resort, Winnetka 66
Mary Pogue School, Wheaton, Ill. 67
Stokes Sanitarium, Louisville, Ky. 68

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RADIUM

Central X-Ray & Clinical Laboratory, 58 E. Washington, Chicago 65
Physicians Radium Assn., Chicago 2 63
Radium & Radon Corp., Chicago 2, Ill. 60

Books Received (Continued)

rector of Anesthesia, Vancouver General Hospital, Vancouver, Canada; and M. Kathleen Belton, M.D., Supervisor of Pediatric Anesthesia, Vancouver General Hospital, Vancouver, Canada. The Macmillan Company, New York, 1948. Price $5.50.

A-B-C's of Solfonamide and Antibiotic Therapy: By Perrin H. Long, M.D., F.R.C.P. Professor of Preventive Medicine, Johns Hopkins University School of Medicine; Physician, The Johns Hopkins Hospital. 231 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price $3.50.

Symposia on Nutrition of The Robert Gould Research Foundation. Volume I "NUTRITIONAL ANEMIA" Edited by Arthur Lejwa. The Robert Gould Research Foundation, Inc., Cincinnati, Ohio. October 16-18, 1947.

The Thyroid and its Diseases: By J. H. Means, M.D., Jackson Professor of Clinical Medicine, Harvard University, and Chief of the Medical Services, Massachusetts General Hospital. From the Thyroid Clinic of the Massachusetts General Hospital. Second Edition. Philadelphia and London. J. B. Lippincott Company, 1948. Price $12.00.

The Alcoholic Woman; Case Studies in the Psychodynamics of Alcoholism: By Benjamin Karpman, M.D., Chief Psychotherapist, St. Elizabeths Hospital, Washington, D. C., Sponsored by Washington Institute of Medicine, Research Foundation. Published by The Linacre Press, Washington 6, D. C., 1948. Price $3.75.

Urology for nurses: Oswald Swinney Lowsley, M.D., F.A.C.S., Director of the Department of Urology (James Buchanan Brady Foundation) of the New York Hospital; Consulting Urologist, St. Clare's Hospital and Hospital for the Ruptured and Crippled, New York City, Monmouth Memorial Hospital, Long Branch, N. J., Englewood Hospital, N. J., St. Luke's Hospital, Newburgh, N. Y., St. Agnes Hospital, White Plains, N. Y., Norwalk Hospital, Conn. and Thomas Joseph Kirwin, M.D., F.A.C.S., Attending Surgeon, Department of Urology (James Buchanan Brady Foundation) of the New York Hospital; Visiting Genito-Urinary Surgeon, New York City Hospital; Consulting Urologist, Coney Island Hospital, Monmouth Memorial Hospital, Long Branch, N. J., Benedictine Hospital, Kingston, N. Y., St. Vincent's Hospital, Montclair, N. J. Second Edition. Illustrations by William P. Didusch. J. B. Lippincott Company, Philadelphia, London, Montreal, 1948. 687 pages. $6.00.

A rehabilitation program in a sanatorium is a plan of treatment to counteract the psychosomatic effects of the disease, tuberculosis. In such a program physical retraining, mental and social readjustment are essential and, as an adjuvant to these, vocational training is valuable. A. N. Aitken, M.D., Am. Rev. Tuberc., Jan., 1947.

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THE USE OF STREPTOMYCIN IN TUBERCULOSIS

The Committee on Chemotherapy and Antibiotics of the American College of Chest Physicians submits the following report of the use of streptomycin in tuberculosis.

Nearly all forms of tuberculosis respond to treatment with streptomycin in some degree. However, the drug should by no means be used indiscriminately.

Pulmonary Tuberculosis: It is extremely difficult to lay down hard and fast rules for the use of streptomycin in pulmonary tuberculosis. Especial care in the selection of cases is necessary. The drug has its greatest usefulness in cases with an appreciable amount of exudative disease. In some other cases streptomycin is responsible for symptomatic improvement and the prevention of complications.

1. Definitive treatment: This category includes chiefly progressive lesions of recent origin with little or no destruction of tissue, such as progressive primary tuberculosis and tuberculosis due to hematogenic and bronchiogenic dissemination.

2. Preparation for surgical procedures, including temporary and permanent collapse and excisional surgery. In some cases pneumothorax can be instituted sooner and with greater safety after a course of streptomycin. Not infrequently the drug is of great value in preparing patients as candidates for thoracoplasty. As prophylaxis, streptomycin should be used routinely in excisional procedures.

It must be emphasized again and again that streptomycin is *not* a substitute for sanatorium care and other proven procedures. Rather it is a valuable adjunct to these other measures.

Extrapulmonary tuberculosis: Streptomycin is the only treatment available in miliary tuberculosis and tuberculous meningitis. In such cases early and intensive treatment is imperative. Streptomycin is the treatment of choice for tuberculous sinuses, tuberculosis of the oropharynx, larynx and tracheobronchial tree, tuberculous enteritis and peritonitis, tuberculous otitis media, and tuberculous pericardiatis. In renal tuberculosis, symptomatic improvement is usually prolonged and bacterial conversion occurs in some cases. Tuberculosis of the bones and joints is often improved by streptomycin but chemotherapy is not a substitute for orthopedic surgery when this is indicated.

Streptomycin is valuable as pre-operative and post-operative treatment of tuberculosis in surgery of the genito-urinary tract, surgery of bones and joints, pericardiolysis, incision and drainage of abscesses and fistuectomy.

Streptomycin is administered by intramuscular or deep subcutaneous injection. The optimal regimen for the administration of streptomycin has not been determined. In most forms of tuberculosis results appear to be satisfactory when a dose of .5 to 1 gram a day are

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administered in one or two injections for six to eight weeks. With this mode of therapy complications are very infrequent and in most cases their clinical importance may be discounted. In tuberculous meningitis and miliary tuberculosis treatment should be vigorous; a dose as high as two grams per day for four months, or longer if necessary. In tuberculous meningitis results seemingly are better when intramuscular injection is supplemented by intrathecal injection of from 25 to 50 milligrams every twenty-four to forty-eight hours for two or three months, or as long as this method of administration is tolerated by the patient.

Since drug fastness is apparently closely related to duration of treatment, regardless of the daily dosage, limitation of the period to a few weeks may be effective in avoiding this phenomenon in many cases.

The physician handling a case of tuberculosis would do well to ask himself the following questions before administering streptomycin.

1. Why is streptomycin being used: for definitive therapy, as preparation for surgery, for prophylaxis, or for relief of distressing symptoms?

2. Is the type of lesion present of such a nature as to warrant the use of streptomycin in addition to other available therapy?

3. Can the purpose of chemotherapy be accomplished within the relatively short period of the drug's effectiveness? (Almost three-fourths of the patients show resistant organisms after three to four months of continuous daily streptomycin treatment.)

There is no other substance known today which compares with streptomycin in its effectiveness against tuberculosis. The sulfones, promin and promizole, are generally ineffective alone. Experimental work is in process to determine whether or not there is synergistic action when any of these are added to streptomycin. Para-aminosalicylic acid is promising on the basis of laboratory experimentation but sufficient clinical work has not yet been done to permit evaluation of this drug. Subtilin has not had sufficient clinical trial and there is not yet enough animal experimentation to indicate its usefulness. Of the many other antibiotic substances, none has shown in preliminary experimentation indication of real value against tuberculosis and none has had clinical trial.

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TREAT RESPIRATORY INFECTIONS WITH PENICILLIN DUST

Inhalation of penicillin dust is a valuable treatment for the common cold, chronic sinusitis, bronchitis, bronchial asthma with acute or chronic bronchitis, and pneumonia, report three physicians.

Writing in the October 2 issue of The Journal of the American Medical Association, the physicians describe a test of the treatment in 357 cases.

Louis Krasno, M.D., is from the Department of Clinical Science of the University of Illinois Medical School; Paul S. Rhoads, M.D., is from the Division of Medicine, Northwestern University Medical School; and Mary Karp, M.D., is from the Division of Surgery, Northwestern University Medical School, and the Department of Anesthesiology, Wesley Memorial Hospital and Passavant Memorial Hospital.

Of the 169 patients treated for the common cold, 42 per cent were considered cured. Thirty-eight patients were treated for acute and chronic sinusitis, 41 were treated for acute and chronic bronchitis, and 24 were treated for bronchial asthma with acute or chronic bronchitis. Of these, 13, 17, and four patients respectively were freed of symptoms. Four out of six patients treated for pneumonia were freed of symptoms. Other patients in the study were treated for various other infections of the respiratory tract.

Penicillin dust often relieves the stuffiness and congestion of a cold immediately, the physicians say. It also reduces the pain of an acutely sore throat within one half to one hour following treatment in some cases, they found.

Of the entire group, 134 patients, or 37.5 per cent, were judged "greatly improved," and 129 patients, or 36 per cent, were judged "moderately improved."

The treatment consisted of inhaling penicillin dust one to three times daily. Three to six minutes were usually required to inhale the amount used, and patients were not allowed to eat or drink for one hour after each inhalation.

Some of the patients used a plastic mouth

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inhaler. This type of apparatus reduces the possibility of allergic reactions from the penicillin dust as it keeps the penicillin from coming in contact with skin of the face, the physicians emphasize.

Only 3 per cent of patients who used the plastic inhaler showed allergic reactions — irritation of the throat and inflammation of the mouth.

Inhalation therapy with penicillin dust permits a patient to "go about his business without loss of time, and with minimum expense," they point out, adding:

"Before the use of the present method, many patients with chronic pulmonary disease were not given adequate treatment because of the expense of prolonged hospitalization and equipment."

Five patients have been given treatment with streptomycin dust by the physicians, but sufficient data are not available to permit a clinical evaluation.

The diagnosis of pulmonary tuberculosis is simple and uncomplicated only if adequate positive data is readily obtained. The patient with obviously extensive chest film findings and sputum positive for tubercle bacilli presents no diagnostic problem. At that stage, with probable far advanced disease, he presents no therapeutic problem — the pulmonary disease is far advanced — the prognosis guarded. Rubin H. Kaplin, M.D. and Louis J. Levin, M.D., Missouri M.A., Jan., 1948.

The tubercle bacillus seems to select its tissue and confine its ravages there. Patients with lupus vulgaris rarely have active glandular, osseous and pulmonary tuberculosis in addition to cutaneous lesions. Patients with mixed tuberculosis are rare. The number of cases of pulmonary tuberculosis in which lesions of skin, bone or gland developed was comparatively small. Henry E. Michelson, M.D., J.A.M.A., April 17, 1948.

The tasks of health education are not merely to teach the facts of the modern science of hygiene but ultimately to persuade men to apply these facts. Motivation in Health Education. Iago Galdston, M.D., Columbia Univ. Press, 1948.



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REPORT OF THE FIRST ANNUAL BLOOD BANK MEETING

The First Annual Meeting of the American Association of Blood Banks was held in Buffalo, New York at the Hotel Statler, August 26 through 28, 1948, immediately following the International Hematology Society Meeting.

Approximately two hundred persons attended various sessions of the meeting and, in addition, a number of foreign guests. The registrants represented twenty-eight states and six foreign countries. Much interest was indicated in the program presented which included both scientific and administrative papers. In addition to the papers indicated on the printed program, a paper on "Transfusion Reactions Using Stored Blood" was also given by Dr. Carlos Munoz Barratta of Lima, Peru.

The meeting was well attended by doctors representing practically every section of the country. Membership in the Association is available to ethical, independently operating and policy-making, non-profit institutions, including those operated by A.M.A. registered hospitals, engaged in blood banking. Associate Institutional memberships are also available to hospitals having no blood bank but interested in blood banking. Individual memberships are open to any person interested in blood banking.

PRIZE FOR OBSTETRICAL PAPERS

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of 'The Foundation Prize.' Authors of papers on obstetrical or gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.


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VOL. 94 NO. 6

December, 1948

Clinical Interpretation of Sternal Puncture

Management of Peptic Ulcer

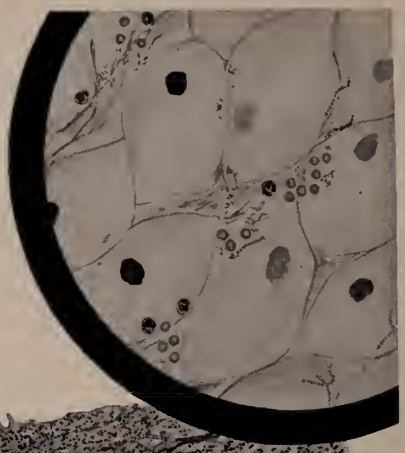
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... and Other Original Articles

(See page 5 for complete Table of Contents)

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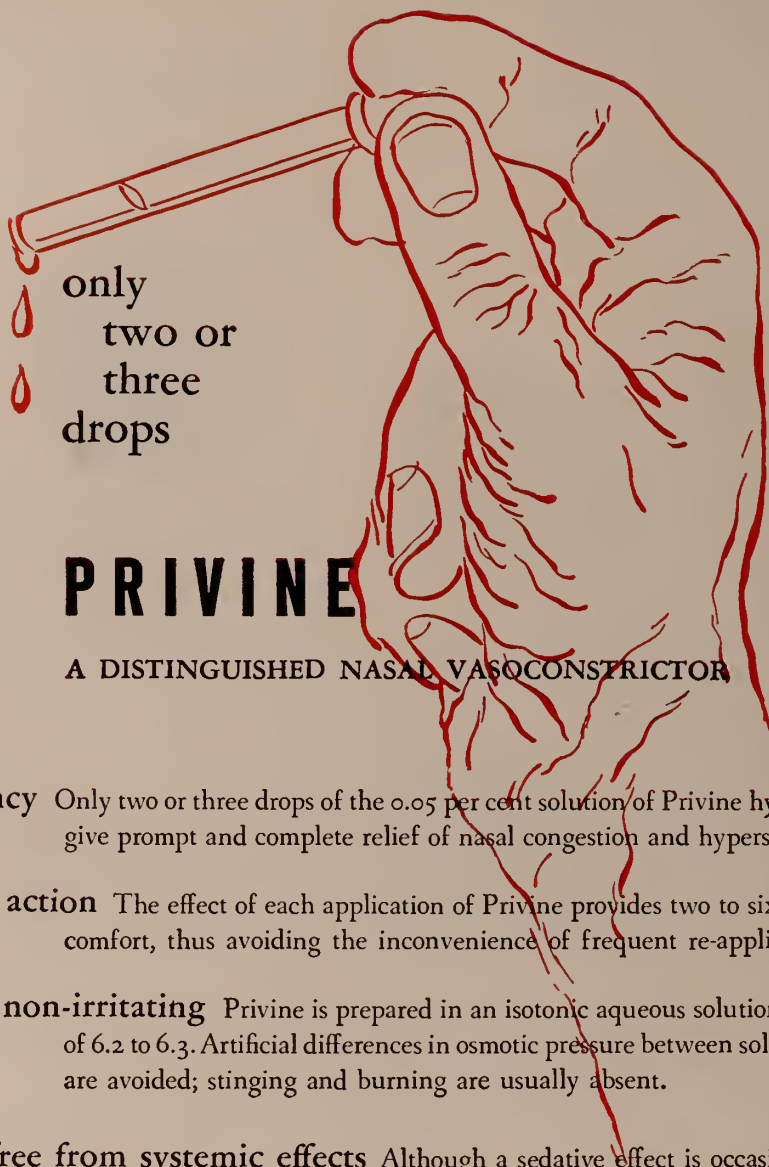
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TABLE OF CONTENTS

DECEMBER, 1948
Vol. 94, No. 6

INDEX TO VOLUME 94 391

ORIGINAL ARTICLES

The Clinical Interpretation of Sternal Puncture, *Paul L. Bedinger, M.D.,* and *Louis R. Limarzi, M.D.,* Chicago 351

The Present Management of Peptic Ulcer, *Joseph B. Kirsner, M.D.,* and *Walter Lincoln Palmer, M.D.,* Chicago 357

Delay in Treatment of Cancer, *Faye E. Bates, M.A.,* and *Irving M. Ariel, M.D.,* Hines 361

Follow-up Studies of Patients with Pre-Frontal Lobe Lobotomy, *Jack Coheen, M.D.,* Elgin 366

Mass X-ray Examination Using Miniature Films, *Clifton Hall, M.D., M.P.H.,* Springfield 369

Roentgen Ray Aspects of Malignancies of the Small Intestines, *Edwin L. Rypins, M.D.,* Bloomington .372

Toothpick in Ascending Colon, Case Report, *C. W. Olsen, M.D., G. E. Johnson, M.D., F.A.C.S.,* and *George Bilek, M.D.,* Chicago 374

EDITORIALS

Full Approval Given to Chicago Medical School ...337

Death of Dr. William A. Evans 338

"Politicians, M.D." 338

Cancer Symposium is for You 339

Council Meeting Minutes, November 7, 1948 376

Book Reviews 56

STATE DEPARTMENT OF PUBLIC HEALTH

Mt. Vernon, State Tuberculosis Sanatorium, *Roland R. Cross, M.D.,* Springfield 340

MEDICAL ECONOMICS

Postmortems 343

CORRESPONDENCE

Your Mental Hospitals, "Method of Admission" ..347

American Goiter Association to Meet in Madison ..348

National Gastroenterological Association 1949 Award Contest 348

Crippled Children's Division Lists January Clinics .349

Crerar is Largest Medical Library in the Midwest .349

Examiners May Earn Retirement Credit 350

Annual Clinical Conference 350

Sale of U. S. Savings Bonds in Illinois 350

PHYSICAL MEDICINE ABSTRACTS 44

NEWS OF THE STATE 379

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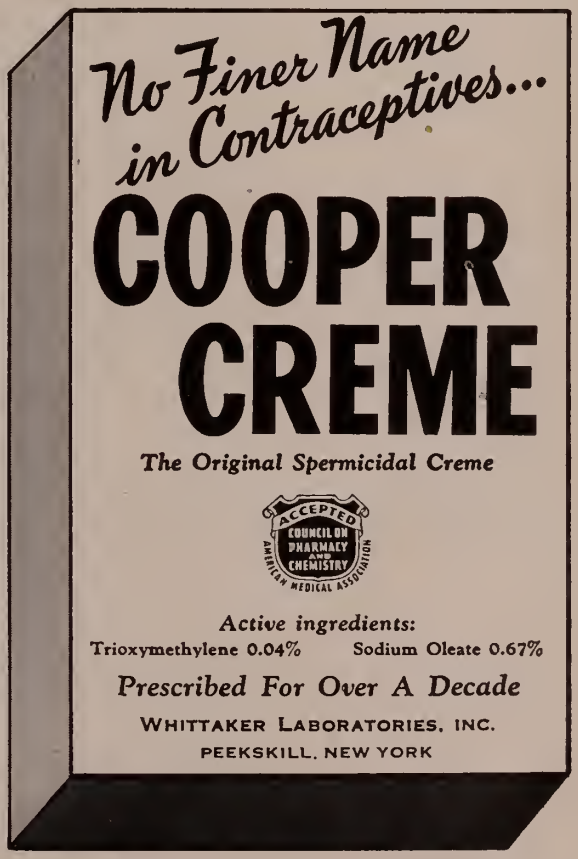
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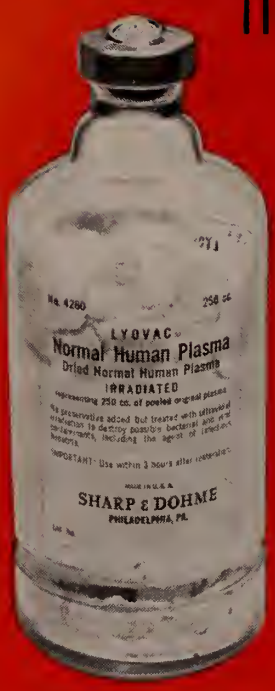
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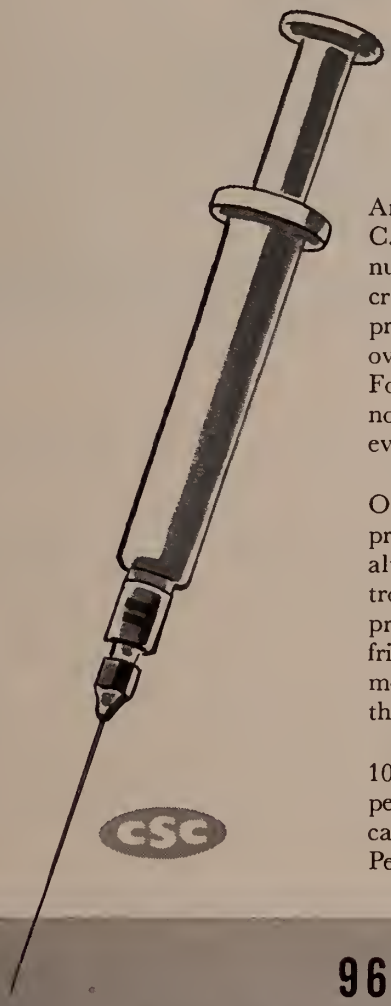
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Two delicately balanced approaches to the problem of the menopause

Conestron oral therapy provides an especially flexible method of prescribing for the progressive physical and mental adjustments of the menopause. This method results in a minimum feeling of distress . . . a maximum feeling of well-being . . . for the patient. *Conestron consists of water-soluble, estrogenic substances from natural sources. Two strengths—0.625 mg. and 1.25 mgs. Bottles of 100 and 1000 tablets.*

To supplement your advice and to enable your patients and their families to arrive at a better home adjustment during this difficult menopausal period, the booklet "*Through One of Life's Progressive Changes*" is available to physicians, gratis, in distribution quantities.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Wyeth PHILADELPHIA 3, PA. **Conestron®**

Orally Active • ***Well Tolerated***

Estrogenic Substances (Water-Soluble)



Clear the airway

with

GLUCO-THRICIL®

antibiotic nasal decongestant

GLUCO-THRICIL promotes prompt and sustained relief from the discomforts of nasal obstruction. Combining, in stable solution, the membrane-shrinking action of ephedrine with the non-sensitizing, high antibacterial activity of Tyrothricin, it increases nasal ventilation and minimizes the possibilities of bacterial invasion.

GLUCO-THRICIL's low tissue toxicity, its isotonicity and pH within the range of those of normal nasal secretions, and its low surface tension, permit wide clinical application in both prophylaxis and treatment.



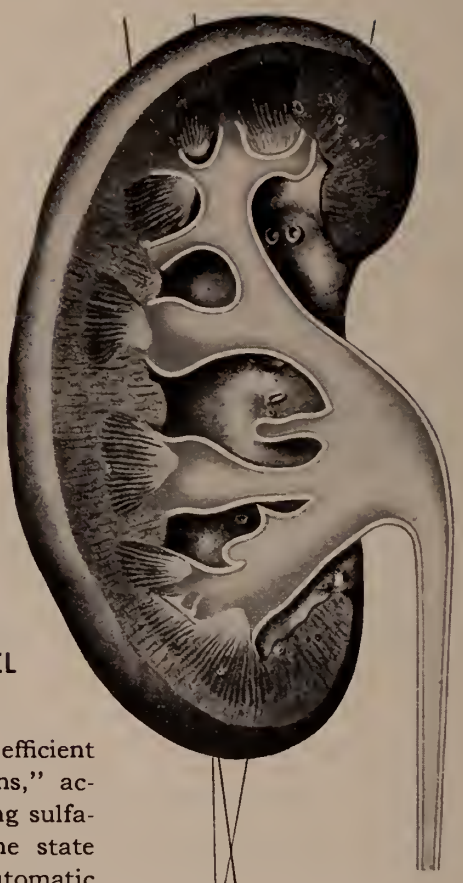
The head-low-lateral position is recommended for administration of GLUCO-THRICIL: adults, 2 to 4 drops in each nostril, three or four times daily; children, 1 to 2 drops in each nostril, three times daily. May also be given as spray or nasal pack.

GLUCO-THRICIL: 1-ounce bottles with dropper cap, and 1-pint bottle. Each fluidounce represents: ephedrine (as the lactate) 1%; Tyrothricin, 1:5000, in an isotonic dextrose solution containing cetyl trimethyl ammonium acetate as a solubilizing and stabilizing agent.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

MEDICAMENTA VERA

A Higher Standard In Sulfonamide Therapy



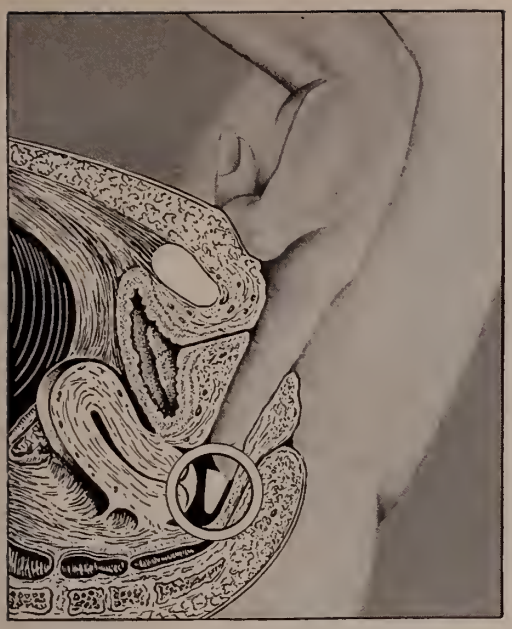
REDUCED RENAL HAZARD
MORE RAPID INSTITUTION OF BLOOD LEVEL
AUTOMATIC ALKALIZATION

Use of sulfonamide mixtures, called "the most efficient single measure to minimize renal complications," accounts for the superiority of Aldiazol. Presenting sulfadiazine and sulfathiazole in a microcrystalline state together with sodiums citrate and lactate for automatic urinary alkalization, Aldiazol produces more rapid initial sulfonamide absorption, leads to satisfactory maintenance of therapeutic blood levels, and almost completely eliminates the danger of crystalluria (2 per cent). It does not burden the kidneys unnecessarily as does sodium bicarbonate alkalization. Aldiazol thus combines high efficacy with minimal toxicity. The palatability of this liquid preparation makes it especially useful in pediatrics. Indicated whenever sulfonamide therapy is called for.

SE M Co

Aldiazol

THE S. E. MASSENGILL COMPANY
Bristol, Tenn.-Va.
NEW YORK • SAN FRANCISCO • KANSAS CITY



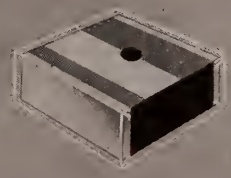
PELVICINS simplify the problem of introducing high concentrations of penicillin directly at the site of vaginal infection, achieving optimal efficacy of the drug in cervicitis and other gynecologic conditions.[1] *PELVICINS* provide 100,000 units of crystalline penicillin G (potassium salt) in each suppository. Even where primary pathogens are not penicillin-sensitive, *PELVICINS* are of proved value in the elimination of susceptible secondary invaders, thereby enhancing the effectiveness of such additional medical or surgical measures as may be indicated. *PELVICINS* are supplied in boxes of 6 and 12, individually wrapped in aluminum foil.

1. Walter, R. I.; Goldberger, M. A.; and Lapid, L. S.; New York State J. Med. 48: 1159 (May 15) 1948.

Schenley LABORATORIES, INC.

350 FIFTH AVENUE, NEW YORK 1, N. Y.

Extra **Protective** *Feature*



Additional protection against moisture is provided by a special wax coating on the package itself.

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Comparative Studies Establish the OUTSTANDING EFFICACY of this Antihistaminic

Quantitative studies to determine the relative efficacy of six leading antihistaminic compounds have demonstrated that Neo-Antergan possesses a considerably greater protective power against histamine than do any of the other antihistaminic drugs tested.*

*Friedlaender, A. S., and Friedlaender, S., *Correlation of experimental data with clinical behavior of synthetic antihistaminic drugs. Paper read before Fourth Annual Session, American College of Allergists, New York City, March 12, 1948.*



Your local pharmacy stocks Neo-Antergan in 25-mg. and 50-mg. tablets, supplied in packages of 100 and 1,000.

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

The newest giant stride in penicillin therapy . . .

DEPO*/penicillin

MAINTAINS THERAPEUTICALLY EFFECTIVE BLOOD LEVELS FOR 96 HOURS IN THE MAJORITY OF PATIENTS

Upjohn is privileged to announce the newest in the series of giant strides in penicillin therapy—DEPO-PENICILLIN—96-hour therapeutically effective blood levels made possible with a single injection of Upjohn's uniquely prepared Crystalline Procaine Penicillin G suspended in Peanut Oil containing 2% W/V Aluminum Monostearate. The Upjohn process of suspending smaller than 5 micra particles of Crystalline Procaine Penicillin G in Peanut Oil gelled with a dispersing agent also affords a free-flowing preparation which may be kept at room temperature.

DEPO-PENICILLIN is recommended for use in all those conditions in which other forms of repository penicillin have been indicated.

*Trademark

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FINE PHARMACEUTICALS SINCE 1886

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FLAT SPRING DIAPHRAGM

Physician's package and complete description of the *New Technique* will be sent upon request.

Ethically promoted—Advertised only to the medical profession.



Accepted by the Council on Physical Medicine of the American Medical Association.

Easily Fitted—The Lanteen Flat Spring Diaphragm, collapsible in one plane only, is easily placed without an inserter.

Remains in Position—The flat spring rim of the Lanteen Diaphragm gently but firmly holds the diaphragm in place even during changes in body position.

Long Lasting—Lanteen Diaphragms, made of the finest rubber, are guaranteed against defects for a period of one year.

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900 North Franklin Street, Chicago 10, Illinois



During the *"springing-up"* period... give them

. . . the natural vitamins A and D—in tablets so remarkably pleasant tasting that children delight in chewing them.

. . . a well tolerated form—no excess calories, appetite is not affected.

. . . full potency—each tablet is equivalent, in vitamin content, to one teaspoonful of cod liver oil* and supplies 312 units of vitamin D, wholly derived from cod liver oil, and 3,120 units of vitamin A supplied by cod liver oil concentrate adjusted and standardized with fish liver oils.

. . . an economical preparation—especially suited to maintaining antirachitic protection through the growth years. Also available in "drop-dosage" Liquid for infants and in higher potency capsules.

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White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

White's Cod Liver Oil Concentrate Tablets

One of White's Integrated Pediatric Vitamin Formulas

*U.S.P. Minimum Requirements

low incidence of uterine bleeding with the potent synthetic estrogen... DIENESTROL

RECENTLY, Rakoff and co-workers* have observed that the incidence of uterine bleeding is significantly low when menopausal syndromes and related entities are treated with White's Dienestrol—a new, highly effective estrogen. In addition Dienestrol was found to be unusually well tolerated; clinical side effects are almost nonexistent.

Available: DIENESTROL TABLETS: 0.1 mg. (white) and 0.5 mg. (red) in bottles of 100 and 1,000.

AQUEOUS SUSPENSION OF DIENESTROL: In 10 cc. rubber-stoppered vials, 5 mg. of Dienestrol per each cc.

*Rakoff, A. E.; Paschkis, K. E. and Cantarow, A.: A Clinical Evaluation of Dienestrol, a Synthetic Estrogen, J. Clin. Endocrinol., 7:688-700 (Oct.) 1947.

White's

DIENESTROL

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

WHITE LABORATORIES, INC.,
Pharmaceutical Manufacturers, Newark 7, N. J.



The First X-Ray...

Medicine and Dentistry thank Wilhelm C. Röntgen (1845-1923), director of the Physical Institute of the University of Würzburg, for discovery of the X-ray.

A barium platinocyanide screen, glowing brightly in the dark in the course of one of his laboratory experiments with a Hittorf-Crookes tube, put the Bavarian physicist on the trail of the invisible ray.

Further investigation disclosed its great penetrative and photographic powers. His first photograph recorded the bones of Frau Röntgen's hand. A "preliminary communication" on his discovery was released on December 28, 1895, to the president of the Physical Medical Society of Würzburg—and the X-ray, so named by Röntgen for want of anything more definitive, was promptly welcomed in medical and dental circles.

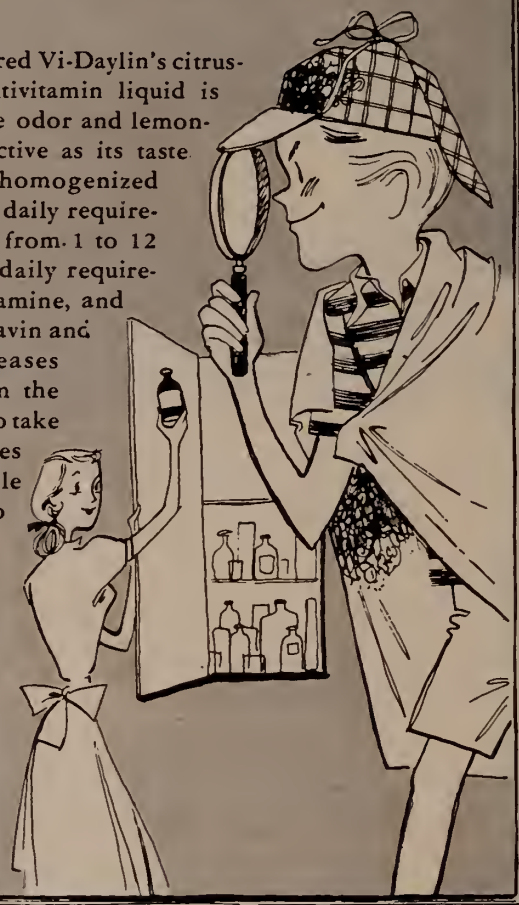
Doctors Today still rely not only upon the X-ray, but also upon another professional safeguard which came into being less than four years after the X-ray itself: the malpractice insurance policy with which The Medical Protective Company assures doctors *complete* protection, *preventive* counsel and *confidential* service.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection EXCLUSIVELY . . . *since 1899*

CHICAGO: T. J. Hoehn, E. M. Breier and W. R. Clouston, Representatives, 1142-44 Marshall Field Annex Bldg., Tel. State 2-0990—ROCHESTER: F. A. Seeman, Representative, Tel. Rochester 6481

The Case of the
TELL-TALE TASTE



● Once little tongues have savored Vi-Daylin's citrus-like flavor, this palatable multivitamin liquid is much in demand. Its citrus-like odor and lemon-honey appearance are as attractive as its taste. One 5-cc. teaspoonful of this homogenized mixture contains the minimum daily requirement of vitamin A for a child from 1 to 12 years old, twice the minimum daily requirements of vitamins D, C and thiamine, and supplemental amounts of riboflavin and nicotinamide. ● Vi-Daylin pleases mothers too. Administers from the spoon for children old enough to take it this way or, for infants, mixes with cereal, milk or juices. Stable at room temperature. Has no fishy odor. Make it easy for the mother and pleasant for the child. Prescribe Vi-Daylin for your next little patient who requires vitamin supplementation. At pharmacies everywhere—in 90-cc., 8-fluidounce and 1-pint bottles. ABBOTT LABORATORIES, North Chicago, Illinois.

VI-DAYLIN
TRADE MARK
(VITAMINS A, D, B_1, B_2, C AND NICOTINAMIDE IN LIQUID FORM)

In the **J.A.M.A.**'s "QUERIES AND MINOR NOTES"...

an authority lists eight specifications for a preparation to use in the nose:

1. It "should have a moderate decongestant effect."
2. It "may contain . . . penicillin."
3. It "should not vary greatly in . . . pH (5.5 to 6.5) from that of normal nasal secretions."
4. "Nor . . . be harmful to ciliary action."
5. It "should not injure the nasal mucosa."
6. It "should be isotonic with the blood."
7. It "should not cause undue secondary side reactions."
8. It should not "cause the blood pressure to rise unduly."

Each of these specifications is fulfilled by

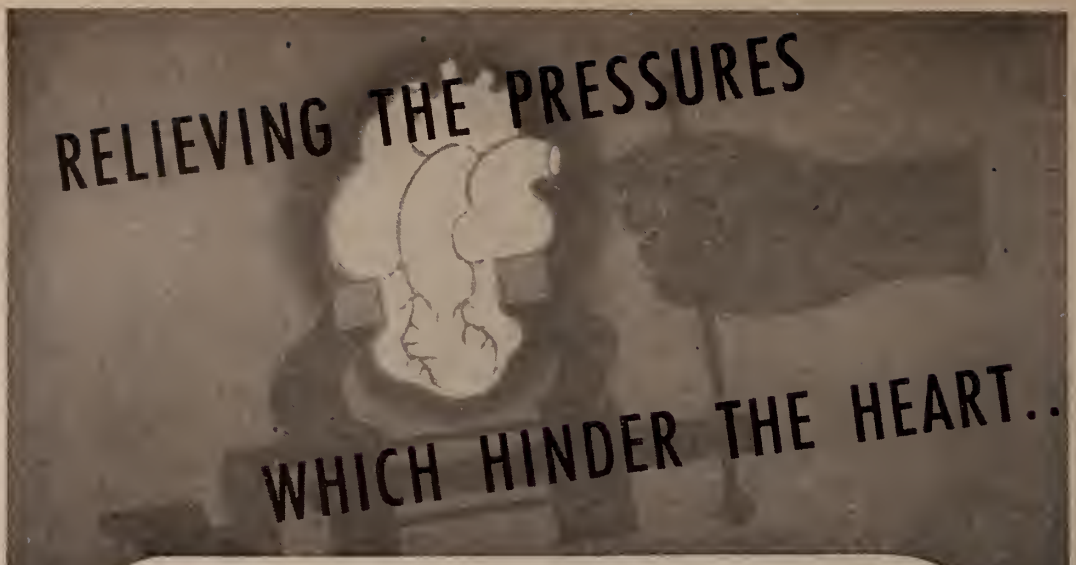
Par-Pen

the penicillin-vasoconstrictor combination for intranasal use*

For samples and full information, write Par-Pen on your prescription blank and mail it to us at 1530 Spring Garden St., Philadelphia 1, Pa.

Smith, Kline & French Laboratories, Philadelphia

*Sodium crystalline penicillin, 500 units per cc.; Paredrine hydrobromide 1%



The accumulation of fluid in edematous tissues imposes excessive strain on the heart, impairing its normal function. Cardiac action becomes labored. Myocardial tone diminishes.

THEODIATAL* *Capsules* provide: direct stimulation of the myocardium to greater efficiency . . . mild but prolonged diuretic action, draining peripheral water excess . . . dilatation of peripheral and coronary vessels . . . bronchodilatation, relieving respiratory embarrassment . . . gentle sedation, calming mental distress.

Each **THEODIATAL** *Capsule contains:*

Phenobarbital (Warning: May be habit-forming)	30	mg.	(1/2 gr.)
Theobromine	66	mg.	(1-1/10 gr.)
Sodium Theobromine	0.13	Gm.	(2-1/5 gr.)
Potassium Iodide	60	mg.	(1 gr.)
Sodium Salicylate	0.11	Gm.	(1-7/10 gr.)

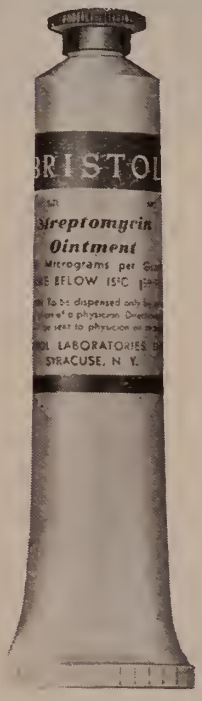
SUPPLIED: In bottles of 30, 125, 500, and 1,000 capsules.

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TRADEMARK
CAPSULES

*Exclusive trademark of E. E. Kunze, Inc.

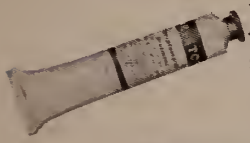
E. E. KUNZE, INC.
MILWAUKEE 4, WISCONSIN

Streptomycin *is now available in* Ointment *form*



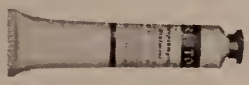
Here is another original contribution to the antibiotic armamentarium from Bristol Laboratories: streptomycin sulfate for topical application, in a smooth, greaseless, ointment base. This significant development of Bristol research is noteworthy for the following:

1. A Broad Antibacterial Spectrum



The variety of bacteria destroyed or inhibited by streptomycin is remarkably broad. Its antibacterial spectrum surpasses those of other antibiotics in current use for topical application.

2. Less Sensitizing



Streptomycin in ointment form minimizes the greatest single objection to topical antibiotic therapy in that it is demonstrably less sensitizing.

3. A Water-Soluble Ointment Base



Bristol Streptomycin Ointment is unusually pleasant to use, because it is incorporated in a smooth, water-soluble base. Despite the fact that there is no grease or oil, adequate potency can be expected to persist throughout the full dating period of nine months after manufacture.

Bristol STREPTOMYCIN OINTMENT is indicated in skin and wound infections due to streptomycin-sensitive organisms. Each gram of the ointment contains 5000 micrograms of pure streptomycin.

Available NOW from your usual source of supply, in 1 oz. tubes, singly, or packed 12 to a carton.

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK

for the convalescent



hemoglobin build-up

PLUS nutritional support

Slow regeneration of blood is one of the most frequent—and often unappreciated—reasons for delayed and inadequate convalescence after both acute and prolonged illnesses as well as after surgery. This is not surprising since even in otherwise healthy individuals a drop of only 10 or 15 percent in the hemoglobin level commonly produces definite asthenia and easy fatigability. Cytora is of particular value for convalescents because it provides important factors necessary for rebuilding blood plus other dietary essentials; each Cytora tablet supplies liberal quantities of iron, folic acid, liver concentrate, vitamin C and five B-complex factors. The pharmaceutical skill exercised in compounding Cytora tablets assures optimal absorption of the active ingredients and minimizes gastric disturbances. Cytora also eliminates a senseless multiplication of medications for the convalescent who might otherwise require several individual medicinal agents to rebuild his blood and improve his nutrition. Cytora is available in bottles of 100, 250, and 1000 tablets.

ROCHE-ORGANON INC., ROCHE PARK, NUTLEY 10, N. J.

CYTORA

'Roche-Organon'

T M—Cytora — Reg. U. S. Pat. Off.

DAILY DOSE (6 TABLETS) PROVIDES:

Ferrous Sulfate	600.0 mg
Folic Acid	4.5 mg
Liver Concentrate	900.0 mg
Vitamin C	150.0 mg
Vitamin B_1	6.0 mg
Vitamin B_2	6.0 mg
Vitamin B_6	3.0 mg
Niacinamide	30.0 mg
Calcium Pantothenate	6.0 mg

plus other factors naturally present in liver concentrate

Available in bottles of 100, 250 and 1000

middle age + emotional tranquility

In many women, the physical distress of the menopausal syndrome is aggravated by emotional instability. ***"Premarin"*** *therapy, in the majority of cases, is synonymous with prompt relief of physical discomfort as well as restoration of emotional calm.*

In addition, there is a "plus" in ***"Premarin"*** *therapy... the gratifying "sense of well-being" so frequently reported following the administration of this naturally occurring, orally active estrogen.*

Flexible dosage regimens to adapt treatment to the particular needs of the patient are made possible with ***"Premarin"*** *Tablets of 2.5, 1.25, or 0.625 mg., and liquid—0.625 mg. per 4 cc. (one teaspoonful.)*

While sodium estrone sulfate is the principal estrogen in ***"Premarin,"*** *other equine estrogens... estradiol, equilin, equilenin, hippulin... are probably also present in varying amounts as water soluble conjugates.*



* Conjugated Estrogens (equine)

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"PREMARIN"®

Ayerst

Ayerst, McKenna & Harrison Limited

22 East 40th Street, New York 16, N. Y.

* strogenic Substances (water soluble) *also known as* Conjugated Estrogens (equine)

Experience is the Best Teacher



John William Ballantyne

(1861-1923)

proved it in obstetrics

BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. At the same time, other obstetricians were beginning to realize the necessity of greater attention during the ante partum period as a result of their investigations of eclampsia. It remained for Ballantyne, however, to be the first to establish a clinic for the expectant mother. World-wide acceptance of his concepts quickly followed Ballantyne's successful experiences in prenatal supervision.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



EXPERIENCE IS THE BEST TEACHER IN CIGARETTES, TOO!

Yes, experience *is* the best teacher in choosing a cigarette! Millions of smokers who have tried and compared many different brands of cigarettes have found that Camels suit them best.

Try Camels. See if your *own* taste doesn't appreciate the rich, full flavor of Camels. See if your *own* throat doesn't welcome Camel's cool, cool mildness.

Let your own experience tell you why, with scores of smokers who have tried and compared, Camels are the "Choice of Experience."

According to a Nationwide survey:

More Doctors Smoke CAMELS

than any other cigarette

In a nationwide survey by three independent research organizations, 113,597 doctors were asked to name the cigarette they smoked. More doctors named Camel than any other brand.



the taste tells the story

Patients with stomach disorders are generally squeamish about their foods or medicines. Your patient's battle is half won if he can look forward *with pleasant anticipation* to 'taking his medicine' instead of being upset or annoyed at the prospect. With the obstacle of objectionable taste eliminated and the patient in the proper frame of mind, the ameliorative action of pleasant-tasting Gelusil* Antacid Adsorbent is consequently enhanced. Relief is almost immediate with Gelusil* Antacid Adsorbent and unlike ordinary alumina gels, it leaves the patient practically free of constipating after-effects.

Indications: Gelusil* Antacid Adsorbent is indicated for the relief of gastric hyperacidity resulting from dietary indiscretions, nervous or emotional disturbances, food intolerances or in peptic ulcer therapy.

*T. M. Reg. U. S. Pat. Off.

Package Description

Dosage: Two teaspoonfuls of Gelusil* Antacid Adsorbent (liquid) or two Gelusil* tablets may be given between meals as often as necessary to relieve symptoms of hyperacidity and promote recovery. Gelusil* tablets are particularly adaptable for the ambulant patient.

Package Information

Gelusil* Antacid Adsorbent is supplied in bottles containing 6 and 12 fluidounces. Gelusil* Antacid Adsorbent tablets are supplied in bottles of 50, 100 and 1000.

GELUSIL

WILLIAM R. WARNER & CO., INC. New York • St. Louis



The "deep down" cough...

RELIEF + DECONGESTION

SYNEPHRICOL®

decongestive cough syrup

In the tight, uncomfortable bronchial cough accompanying colds, influenza or bronchitis, Synephricol provides the decongestion necessary to permit free breathing. and elimination of excess mucus.

Synephricol is expectorant, and more—it thins the viscous mucoid bronchial secretions and it decreases bronchial irritation by sympathomimetic action.

EACH TEASPOONFUL OF PLEASANT FLAVORED SYNEPHRICOL CONTAINS:

Codeine phosphate	8.7 mg.
Neo-Synephrine® hydrochloride	5.0 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.0166 cc.
Alcohol	8%

Exempt narcotic

Average adult dose: 1 or 2 teaspoonfuls every four hours.
Supplied in bottles of 1 pint and 1 gallon.

Winthrop-Stearns INC.
NEW YORK 13, N. Y. WINDSOR, ONT.

SYNEPHRICOL and NEO-SYNEPHRINE, trademarks reg. U. S. & Canada



SULAMYD FOCUSES ON THE *colon bacillus*

commonest cause of urinary tract infections . . .

SULAMYD* searches out and attacks *B. coli* so rapidly that "results that follow its use are uncanny. Occasionally the urine is sterile at the end of one day's treatment."[1]

RECOVERY or improvement in 98% of 200 cases of acute and chronic infections of the urinary tract was noted by Welebir and Barnes,[2] typical of the brilliant results achieved with SULAMYD. For prophylaxis, too,

SULAMYD

(Sulfacetimide-Schering)

is the chemotherapeutic agent of choice. In a group of 4,000 women treated prophylactically with various sulfonamides after pelvic surgery, SULAMYD proved the most effective, reducing urinary complications to less than 1%.[3]

HIGH DEGREE OF SAFETY is coupled with this remarkable antibacterial action. Highly soluble either in alkaline or acid urine and rapidly eliminated by the kidneys in high concentration, SULAMYD has an extremely low toxicity, far less than that of other sulfonamides.[4] Concrement formation has never been reported with SULAMYD.

SULAMYD (Sulfacetimide-Schering) Tablets of 0.5 Gm. in bottles of 100 and 1000. Bottles of 5.0 Gm. powder for laboratory determinations of urine and blood concentrations.

BIBLIOGRAPHY: (1) Wesson, M. B.: West. J. Surg. 49:662, 1941. (2) Welebir, F., and Barnes, R. W.: J.A.M.A. 117:2132, 1941. (3) Younge, P. A.: Urol. & Cutan. Rev. 49:422, 1945. (4) Kearns, W. M., in discussion on Herrold, R. D.: Wisconsin M. J. 41:467, 1942.

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Schering

CORPORATION · BLOOMFIELD, NEW JERSEY

IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

SULAMYD

SCHERING

For the "Difficult" Case of Urinary Infection...
MANDELAMINE



MANDELAMINE* is a urinary antiseptic of choice because its effectiveness is not limited by factors often responsible for slow or unsatisfactory response.

MANDELAMINE *is effective against a wide range of bacteria most often involved in urinary-tract infections.*

MANDELAMINE *is free from danger of drug-fastness.* Moreover, organisms that develop resistance to streptomycin or sulfonamides remain fully susceptible to MANDELAMINE.

MANDELAMINE *is unusually well tolerated.*

MANDELAMINE *is easy to take, and the regimen is uncomplicated,* thus ensuring that the full recommended dosage will be taken.

6 Outstanding Features of MANDELAMINE

1. No gastric upset. 2. No fluid regulation. 3. No dietary restrictions. 4. No need for supplementary acidification (except in presence of urea-splitting organisms). 5. Wide range of antibacterial action. 6. Simple oral dosage—3 or 4 tablets three times daily.

SUPPLIED: Enteric-coated tablets of 0.25 Gm. (3¾ grains) each, bottles of 120, 500, and 1,000.

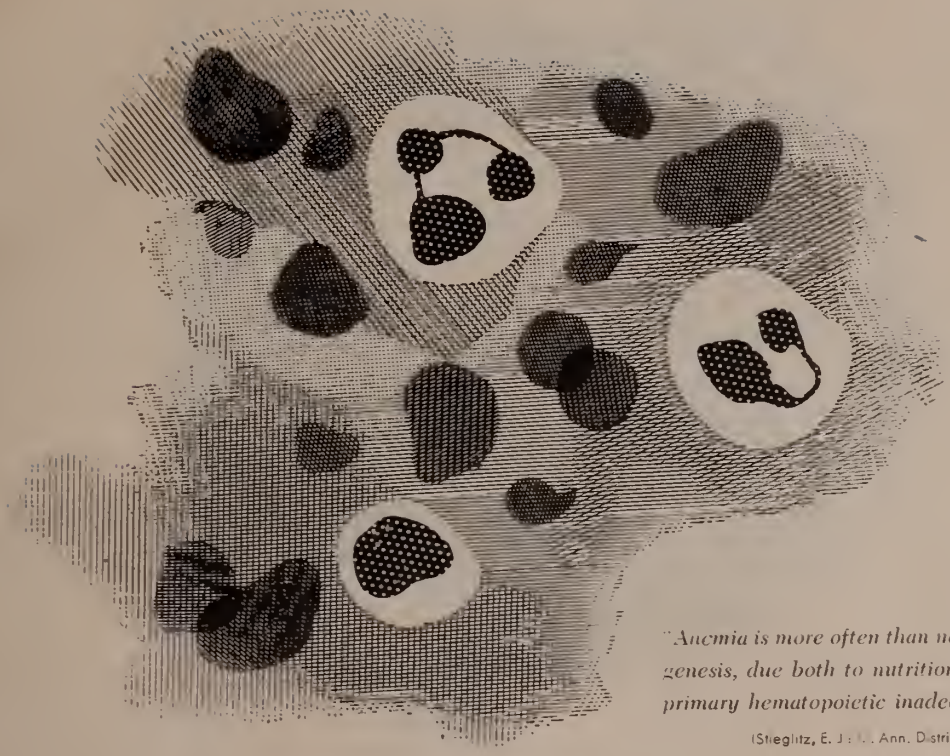
*MANDELAMINE is the registered trademark of Nepera Chemical Co., Inc., for its brand of Hexydaline.

MANDELAMINE
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Brand of Hexydaline
(METHENAMINE MANDELATE)

NEPERA

NEPERA CHEMICAL CO., INC.

Manufacturing Chemists · NEPERA PARK, YONKERS 2, N. Y.



"Anemia is more often than not of mixed pathogenesis, due both to nutritional deficiency and primary hematopoietic inadequacy."

(Stieglitz, E. J.: J. Ann. District Columbia 17: 97, 1948

LIAFON supplies four blood-building essentials in one capsule

DESICCATED LIVER for all secondary antianemia principles of whole fresh liver

FERROUS SULFATE for ferrous iron, the most effective form of iron medication

ASCORBIC ACID to aid absorption and utilization of iron

FOLIC ACID to stimulate bone marrow and help in normal red blood cell development

1 or 2 Capsules t. i. d. • Bottles of 100 Capsules

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SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



Edrisal is a significant advance over ordinary analgesics—*it is the only analgesic containing Benzedrine* Sulfate, the rational anti-depressant.*

Thus Edrisal, besides relieving pain promptly, also brightens your pain-depressed patient's mood. No wonder so many physicians find Edrisal highly effective in a wide range of conditions characterized by pain, *and by the depression that almost always accompanies pain.*

Each Edrisal tablet contains acetylsalicylic acid (2.5 gr.), phenacetin (2.5 gr.), and 'Benzedrine' Sulfate (2.5 mg.). For samples and full information, write us at 441 Arch St., Philadelphia 5, Pa.

*T.M. Reg. U.S. Pat. Off. for racemic amphetamine sulfate, S.K.F.

Smith, Kline & French Laboratories, Philadelphia

Edrisal

its dual action relieves pain, lifts mood



A "One-Product Treatment" for Pernicious Anemia

In the treatment of pernicious anemia it is important to restore and maintain a normal blood picture. Equally important is the prevention of irreversible neurological changes.

Injectable Liver Extracts, Lilly, provide a one-product solution for the treatment of pernicious anemia. With suitable doses, not only is the red-blood-cell count maintained at normal levels, but central-nervous-system degeneration is prevented as well. Fully potent, injectable liver extract solutions are available in strengths of 1, 2, 5, 10, and 15 U.S.P. units per cc.

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Lilly in the Republic of the Philippines

IN 1906, the Medical Department of the University of the Philippines was established. The original faculty consisted of men from the Bureau of Science and other men from the best American medical schools. Now both faculty and staff of the Bureau of Science are almost entirely Filipino, graduated from their own national school. Hospital and medical services have continued to improve, with more emphasis placed upon medical research. Important contributions may be expected from the laboratories of Filipino medical research institutions.

In 1926, Eli Lilly and Company placed its first resident representative in Manila. Since that date, medical research centers in the Republic of the Philippines have been visited regularly. Here, as elsewhere in the world, the Lilly Research Laboratories offer their complete resources for the practical development of mutually interesting problems. Through the teamwork of pure and developmental research organizations, new and improved medication becomes available to all.



The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Vol. 94, No. 6 December, 1948

FULL APPROVAL GIVEN TO CHICAGO MEDICAL SCHOOL

The American Medical Association and the Association of American Medical Colleges granted full approval to the Chicago Medical School on November 9, 1948. Announcement of the approval was made at White Sulphur Springs, Virginia, where the Association of American Medical Colleges was holding its annual meeting. The A.M.A. Council on Medical Education and Hospitals met simultaneously to take action, and a joint statement was issued as follows:

"The Chicago Medical School now offers an educational program that meets the standards for an approved medical school. Therfore, the school is now included on the list of approved medical colleges and hospitals of the A.M.A. and is admitted to membership in the A.M.A.C. This action applies to all students now enrolled in the regular four year course at the school."

This action gives Chicago five approved medical schools, an equal number with New York City, and the action will be welcomed by the Illinois State Medical Society and physicians throughout the state. For several years the Illinois State Medical Society Committee on Medical Education and Hospitals has offered all possible assistance to those in charge of the Chicago Medical School in the effort to meet the requirements for an approved medical school.

Annual reports of this Committee in the past years have shown definite progress on the part of the Chicago Medical School toward that goal. This will be the third approved medical school in the expansion of the West Side Medical Center in Chicago, and the deans of the University of Illinois College of Medicine and Stritch School of Medicine of Loyola University will no doubt heartily endorse the action taken by the two associations in granting this approval to the Chicago Medical School.

The Chicago Medical School received its charter in 1912, and it was the only unapproved medical school in the country in recent years. Thus the action taken by the two Associations, in their joint effort to place medical education in this country on the highest level, will be received with unusual interest by medical educators and many members of the medical profession throughout the country.

The school is affiliated with Mount Sinai Hospital, and clinical work is given at the Cook County Hospital, Municipal Contagious Hospital, and the Chicago State Hospital. It was reported that nearly 300 students are enrolled at the present time in the school. John J. Sheinan is

Dean of the School, and it was stated that their staff is composed of 250 members.

With the approval of a fifth medical school in Chicago, it is most likely that Chicago will again lead the other states in the number of graduates of approved schools each year.

DEATH OF DR. WILLIAM A. EVANS

Dr. William A. Evans, 83, former health commissioner of Chicago and president of the Chicago Medical Society, and for 23 years editor of the Chicago Tribune's "How to Keep Well" column, died Nov. 8 on his plantation near Muldon, Miss. He was to be buried in Aberdeen, Miss., Nov. 11.

Dr. Evans was born in Marion, Ala., in 1865, educated in schools at Aberdeen, Miss., and received his medical degree at Tulane university, New Orleans. In 1891 he moved to Chicago, where he served on the staff of Cook County hospital, Alexian Brothers hospital, and several others. He was president of the Chicago Medical Society in 1902 and 1903, and in 1907 was made city health commissioner. Pasteurization of milk, tuberculin testing of cows, and medical inspection in the schools were initiated under his administration and the typhoid death rate had been greatly reduced before he resigned in 1911 to become health editor of the Tribune. During the 23 years Dr. Evans conducted the "How to Keep Well" column, he received 1,087,447 letters from his readers. He was succeeded as health editor of the Tribune in 1934 by Dr. Irving S. Cutter, then dean of the medical school at Northwestern university. Dr. Cutter died several years ago and the medical column is now written by Dr. Theodore R. Van Dellen.

Dr. Evans presented his home town of Aberdeen, Miss., with a library of some 15,000 volumes and 10,000 manuscripts as a memorial to the Evans family which for generations lived in that section of the state. He also restored the old home of Jefferson Davis, "Beauvoir," in Biloxi, Miss., converting it into a public building now maintained by a Davis memorial association.

Until his retirement, Dr. Evans was well known to the majority of physicians in Illinois and was always interested in the welfare of the medical profession as a whole and of the medical societies of which he was a member for so many years. He was made an Emeritus Member of the Illinois State Medical Society in 1934, and became a member of the Fifty Year Club in 1938.

After his retirement he went back to the old home at Aberdeen, Mississippi, but came back to Illinois frequently. He attended a number of annual meetings of the Illinois State Medical Society. He was interested in the Fifty Year Club, and was no doubt largely responsible for the recent development of a similar Fifty Year Club in Mississippi.

His indeed, was a colorful life, and one of service. For many years he was professor of Pathology at the University of Illinois College of Medicine, then later as Professor of Hygiene and Sanitary Science at Northwestern University Medical School, and his name appears on the diplomas of thousands of physicians in Illinois and throughout the nation.

He will indeed be long remembered by his many friends in Illinois and else where, and all will desire to extend their sympathy to the family of Dr. Evans at his passing.

"POLITICIANS, M. D."

The Lincoln, Illinois Evening Courier recently published an editorial with the above title which is interesting and worthy of commendation. The editorial was as follows:

"Dr. E. L. Henderson of Louisville recently attended the sessions in Rome of the International College of Surgeons—his third European trip in 14 months as a delegate from American medical groups. In his return from the latest journey he said that if the members of congress could see how state medicine works abroad they would never think of introducing it in this country. In every country where socialized medicine is practiced, he added, there has been a decline in the standard of medical care.

"More evidence to the same effect has come from New Zealand, whose government medical program was much praised in this country when it went into effect. The bill for tax-paid medical service rose nearly three times between 1942 and 1947. Even though the politicians had promised unlimited benefits to the voters they were forced to ask the doctors to restrict services to their

patients—a request which the doctors have refused to follow. The burden on the doctors has become so great that in many instances appointments have to be made four months in advance. Patients queque up in the doctor's office whether they need attention or not, on the theory that they have it coming. The whole New Zealand plan has been pretty much of a fiasco and is now in the process of revision.

"The story of what politics does to the practice of medicine is always the same. It can be summed up in a phrase—poorer service and more costly service."

Many people from the United States have made intensive studies during the present year, of the medical care plans in many countries where medicine no longer is practiced as a private enterprise. Stories which have been told by these investigators are quite similar especially relative to the type of medical service which is given under the socialized plans. The editor of The Lincoln Evening Courier is to be congratulated for his efforts to bring to his readers reliable information relative to the effects of compulsory health insurance on the type of service patients receive.

CANCER SYMPOSIUM IS FOR YOU

Dr. Warren H. Cole, Chairman of the Cancer Committee of the Illinois State Medical Society and Chairman of the Professional Education Committee of the Illinois Division, American Cancer Society, Inc., has announced that the Sixth Symposium on Cancer will be held in Chicago, January 24 to 28, 1949, inclusive. This symposium is jointly sponsored by the Illinois State Medical Society, the Illinois Department of Public Health and the Illinois Division of the American Cancer Society. Tuition is waived through the courtesy of the Cancer Society, who will also provide a hotel room in Chicago, reimburse the physician for his railroad fare and furnish a bus each day for transportation to and from places of instruction.

Due to the efforts of the Committee on Rural Medical Service of the State Medical Society and the American Cancer Society the public is becoming increasingly aware of the menace of cancer and its early signs and symptoms. Each physician must accept the responsibility of early diagnosis and adequate treatment. A missed diagnosis means death for your patient. Nearly two hundred Illinois physicians have attended previous courses.

The comprehensive nature of the course is indicated by the schedule: Monday, January 24, at Mercy Hospital (Loyola University Medical School); uterus, adnexa, vulva, technique of biopsy, X-ray diagnosis, testes, bladder, and prostate: Tuesday, January 25, University of Illinois College of Medicine; thyroid, colon, spinal cord, larynx and bronchi, lip and jaw, neck, gall bladder and bile ducts: Wednesday, January 26, Northwestern University Medical School; brain, eye, lung, mediastinum, breast, kidney and ureters: Thursday, January 27, Michael Reese Hospital; skin, leukemias and other blood, a pathological conference, rectum and anus, lymph nodes, radiation therapy breast and cervix, use of blood: Friday, January 28, University of Chicago Medical School; bone, aesophagus, stomach.

Applications should be submitted through the President or Secretary of your local medical society.

GARLIC PROTECTION

Sigerast, the medical historian, in describing an epidemic of yellow fever that swept the Atlantic seaboard in 1791, said: "Mad rumors were afloat as to means of protecting one's self. Women and children went about with huge cigars in their mouths; people chewed garlic all day long or merely kept some in their pockets or in their shoes. In many houses gunpowder, tobacco or alum were constantly kept burning, or vinegar was sprinkled at intervals. . ." — "So Near the Gods," published by The Society of the New York Hospital, 1938.

STATE DEPARTMENT OF PUBLIC HEALTH



Mt. Vernon State Tuberculosis Sanatorium

Roland R. Cross, M.D.,
Director, Illinois Department of Public Health

I suppose that ceremonies have marked the ground-breaking for the construction of thousands of buildings in Illinois — Churches, schools, hospitals and even country clubs.

I suppose that hundreds of thousands of men, women and children have gathered at such ceremonies to witness the lifting of the first spade of earth and by their presence to express their good will and their devotion to the enterprise at hand.

Never before, however, have ceremonies been arranged in Illinois to observe the beginning of construction of a State owned tuberculosis hospital built to serve the public. Never again can anyone witness the first step in the actual construction of the first State hospital in Illinois to be devoted entirely to the care and treatment of our fellow citizens who are the unfortunate victims of tuberculosis.

We are here today to dedicate the beginning of a new venture by our State government. It comes none too soon. It marks the triumphant culmination of the hopes, the dreams and the persistent efforts of civic-minded, forward looking men and women which have run through the public health history of Illinois for more than half a century.

In 1901 an unsuccessful effort was made to obtain an appropriation from the General Assembly for the construction of a State tuberculosis hospital. Since that year bills have been introduced time and again with the same end in view. It was not until 1947, however, that the General Assembly on the recommendation and strong support of Governor Green appropriated the funds and enacted the supporting laws which make possible this program here today.

It is right and proper that this first State tuberculosis hospital should be located in Southern Illinios. Nowhere in our State is the need for such an institution greater. I know this from personal experience and observation. I was born not many miles from this very spot. Near here my children were born. In this vicinity I practiced medicine for many years. From that experience I know what it is to face an anxious father or mother with the tragic news that tuberculosis has invaded the family circle. I know what it is to tell them that the nearest sanatorium is 100 miles or more away.



Percy E. Hopkins, President of the Illinois State Medical Society speaking at ground-breaking ceremonies.



Roland R. Cross, Director, Illinois Department of Public Health, giving the address which appears on these pages.

I know what it is to say that even so the beds are all full — that there is no room for the newly discovered patient. I know how hard it is under such circumstances to answer the simple question — What can we do?

So, I say, it was a wise choice to bring to Southern Illinois the first State tuberculosis hospital. Here it will meet in part at least a long-standing and highly important need. Here it will best serve the purpose for which it is being built.

Although this new hospital will add tremendous striking power to the enemies of tuberculosis, those who wage war against that disease have by no means been idle. We have come a long way since 1901 when tuberculosis was first declared an infectious disease by the State Board of Health. Thanks largely to the Illinois Tuberculosis Association, the county tuberculosis associations, and the county tuberculosis sanitarium boards, we have reached the point where complete victory over tuberculosis need no longer be only a dream and a wishful hope. It can be made a thrilling and profitable reality.

Where once that disease was responsible for 8,000 to 10,000 deaths per year it now take less than 3,000 lives annually in Illinois. Thus we have travelled two-thirds of the way along the rough, unpaved and winding road that leads to ultimate and complete control over tuberculosis. The road ahead will be still more rugged and difficult of passage than that we have left behind. Tuberculosis is a wily, cunning, treacherous and dangerous enemy. It is often found lurking where least expected. We no longer plan to level our sights on the easily detected, far-advanced cases of galloping consumption but we have set as our target the finding of the early cases with minimal lesions that are known to exist unsuspected in about one per cent of apparently healthy adults. Our progress in the future will, therefore, require redoubled efforts, harmony of purpose, strong determination and unrelenting teamwork, pulling together, shoulder to shoulder.

Difficult as the task ahead may be, we are in a most advantageous position to fight a winning fight. We know what causes tuberculosis.

We know how it spreads. We know how to find out whether or not a person has tuberculosis. We know how to prevent the spread of this disease. We know how to treat patients so as to give them a good chance of recovery.

What we need desperately are adequate facilities to use this knowledge advantageously throughout the State. How fast we move forward will depend in no small measure on how rapidly the gaps are filled in the availability of facilities. We are making an important beginning in that direction here today. When completed, the hospital here will have 100 beds, an out-patient department for ambulatory patients, and equipment for occupational therapy and vocational rehabilitation, but Southern Illinois needs 500 new tuberculosis beds in order that the task ahead may be done expeditiously and well. The construction here ought, therefore, to be followed promptly by the construction of one or two more tuberculosis hospitals in this part of the State.

Architect's plans for building a 500 bed State tuberculosis hospital in Chicago are almost complete. It is anticipated that construction on that institution will begin within a few months. But Chicago and vicinity needs about 2,000 new beds in order that victory over tuberculosis in that area may be achieved without undue sacrifice of life and health. Here again new construction ought to follow soon in the Northern strong-hold of tuberculosis.

As things stand today our case-finding program is running ahead of our ability to provide satisfactory care for the cases discovered. By means of seven mobile x-ray units operated by the State Department of Public Health and similar equipment operated by a number of local voluntary and official agencies, thousands of chest x-rays are taken free on volunteers every day in Illinois. About one out of each 100 pictures so taken show evidence of tuberculosis. As a result of these activities, the number of cases already discovered and in need of sanatorium care is greater than the combined bed capacity of all the tuberculosis hospitals in Illinois. There is now and has been for some time a considerable list of tuberculosis victims waiting for vacancies in sanatoriums. This waiting period dulls the prospects for the most rapid recovery on the one hand and increases the chance of spreading the disease on the other.

This situation explains the urgency and the importance of the construction program that starts here today. I hope and believe that the builders will have finished their work; that the grounds will have been graded and landscaped; that furniture and equipment will have been bought and installed; and that the considerable staff of doctors, nurses and non-professional personnel needed for the institution will have been employed by January 1, 1951, so that the sanatorium can be opened for the admission of patients on that date.

This hospital is being built to serve within its capacity all of the people who need its services. Let it be a vital monument to the spirit of good will and of united effort in bringing our forces to bear on a common enemy. Let us dedicate our hearts and our talents to that high purpose.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Emmet B. Bay, Edwin F. Baker, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Ford K. Hick, Edwin F. Hirsch, May McDonald Milligan, Marie Wessels, Walter M. Whitaker, Holland Williamson.



Postmortems

The development of specialized medicine in our country places the responsibilities of the specialist, in lay opinion, at a high level because by implication he should know more and be more skillful in his field of practice than doctors engaged in general practice or in other areas of specialization. Lay thought has no reason to consider how this specialized skill or even the more general training and experience of a physician have been obtained in order to give medical services at the higher levels of practice. However, the large clientelle served by the medical profession justly is interested in the quality of the health product dispensed, both from the standpoint of life enjoyment and the monetary price paid in remuneration for these professional services. Probably this clientelle does not realize that these interests also carry responsibilities vital to the continued improvement of medical practice, and which in effect have positive values in assuring good professional care. Both lay and professional circles appreciate that the physician dealing with the emotional reactions as well as the physical disorders of the body does not have a God-given characteristic for diagnosis or a similar quality for miraculously restoring health. The physician, like every other human, must learn the fundamentals and the refinements of his profession. He can make errors despite honest intentions and skill, which are costly to life and to the functions of living because diseases of the human body are so multiple and the symptoms may be both variable and not specifically characteristic.

When symptoms began to be correlated with disorders of specific tissues of the body, medical practice moved from mysticism to logic. These correlations were effected by establishing through examinations of the bodies of the deceased, the tissues involved by a disease. Patterns of symptoms by which disorders of a specific character were recognized, then became established. The human body because of the multiplicity and complexity of its tissues and their functions has potentials for myriads of symptom patterns, some relatively simple, but others exceedingly complex and overlapping each other. Therapy also ranges from simple effective measures to those which are merely supportive or palliative in a disease where functional tissues have been destroyed and no replacement or correction is possible, or where no measures are known by

which a progressive disorder can be inhibited. This is the fringe into which medical practice gropes to obtain new information or to develop procedures for making a diagnosis and for determining sound therapy. These new attempts at therapy or procedure pass through a testing phase, sometimes initially used with marked enthusiasm, but later found to have a much more restricted application. They are the trends which appear in medical practice, from time to time.

The physician as a medical student first is taught the gross and microscopic structure and physiologic functions of the various tissues of the human body. He then learns about the changes caused by disease in the morphology and physiology of these tissues. In this background develop the principles of correlating symptoms and the physical findings which reflect the nature of the tissue disorders. These are steps, stated simply, which lead the physician into his practice of medicine, supplemented by training in the various technics of treatment. Diagnostic acumen and judgment in therapy develop with experience in practice. This thought indicates that practicing physicians, including the specialists, must improve continually their fund of information to maintain or enlarge their own skill and to keep abreast with medical progress. Diagnostic acumen is the vital element in the development of a skillful practice.

At the student level of training, emphasis was placed on teaching the future practitioner the changes caused by specific diseases in the tissues through material preserved in museums and currently received from the operating rooms or demonstrated during postmortem examinations. No one presumes to think that sufficient instruction of this kind can be offered during the student days of a doctor to suffice for years of practice. Yet probably, some physicians carry on with this modicum of actual tissue experience. Doctors with the greater responsibilities in medical practice, especially those in the specialty branches, must check continually the correctness of their diagnoses in patients in order to enrich and perfect their diagnostic acumen. The opportunities for these experiences rest with the revelations of the postmortem examinations of the bodies of patients who die.

Years ago when a physician began his practice of medicine, opportunities for improving his medical skill beyond the experiences of his practice were limited. Today these are multiple. He finds them in the medical societies, lectures, postgraduate courses, medical journals, and in his own participation in group and hospital staff discussions. At no time in the history of medicine are so many opportunities offered to physicians for continuation studies, organized and given by the members of the profession. Large and many small hospitals emphasize postgraduate training for the attending and resident medical staff, especially in clinical pathological conferences. Here the clinical history and clinical diagnosis of patients dying in the hospital are reviewed, discussed and compared with the results of the postmortem examination. Probably most of these educational activities for continuation study include comments on the morphologic or physiologic changes caused in tissues by disease, in short, the pathology of the disorders. Accordingly then, the diagnostic acumen of the physician depends upon his understanding of the pathologic changes in tissues whether these are dominantly conscious in his thinking, or are subconsciously contributing in his diagnostic conclusions. The closer the physician follows the actual pathology in his patients, the more his mind is alerted to the diseases which cause the symptoms he observes in his patients.

These accumulated experiences improve the quality of the service that the physician can offer his patients and the living clientelle are benefited because the deceased, through the postmortem examinations have improved his diagnostic acumen or have helped him to correct his therapy. Hospitals with a high percentage of postmortems of their deceased patients rank high in the esteem given them in medical circles. From the lay position these should be regarded as better institutions for medical care than those with a low percentage. The postmortem examination probably is the most enlightening and stimulating experience for all physicians participating. The pathologist, to whom is delegated the responsibility of making the examination and of interpreting the tissue changes, serves as an arbitrator. He demonstrates and describes to the others the changes

caused by disease in the tissues and at the same time records his observations for the hospital files. Bacteriologic studies, microscopic and special examinations of the tissues, and photographs are supplemented. This material then becomes available for the conferences to be held later, at which the entire clinical history is reviewed and is compared with the results of the postmortem. To the pathologist the revelation of diseases, anomalies, and unusual conditions in postmortem examinations are a constant source of stimulation and fascinating interest. His curiosity is aroused to see in what manner the disease had expressed itself in the tissues, what are its phases, how can preventive measures be found and applied. These and many other questions flash through his thoughts and fill his mind in later studies. While the prime purpose in each postmortem is to establish the immediate cause of death so far as is possible, the pathologist is provided a much larger field of study. He is able to test the accuracy of his surgical tissue diagnoses (biopsies) which in a large hospital practice and in cancer-control clinics occupy a considerable part of his time. The value of this discipline is again reflected to the advantage of the living clientelle where accuracy in tissue diagnosis is highly important in determining the nature of a disease and thus indicating to the clinician the correct procedures for therapy.

As arbitrator, the pathologist demonstrates to the clinicians the tissue changes revealed by the postmortem examination of their deceased patients and gives them a correlation of the tissue changes with the clinical symptoms of their patients. There is no question that the postmortem improves the quality of diagnosis, and as Alan Gregg has written, it is the terror of the casual guesser, but is a reward to an eager and honest doctor even when it is a stark corrective; and it serves as a merciless incentive to the best we have in us as physicians. The frankness with which clinicians discuss the results of these postmortem examinations reveals an honesty and sincerity of purpose which dispels any suspicion of fear about the disclosures of the examination.

The benefits of the postmortem examination to the lay clientelle are frequently omitted in discussions of the postmortem. The advantages are many; in the improvement of medical practice, and in other ways, to the immediate family and circle of friends. Great satisfaction is gained from knowing that the best medical attention and care was given to the deceased; that a disease not clearly diagnosed during life became factual knowledge later; that a communicable disease was disclosed against which suitable measures could be applied to protect other members of the family or exposed contacts; and that benefits, of an intangible character at the moment, can be realized later. The postmortem offers these and many other advantages not considered during the emotional stress at the time of the death of the relative or friend. It can be used constructively and not regarded as a violation of the sanctity of the human body.

Burial or cremation are the modes permitted by law for the disposal of the dead human body. Custody of the body is a right based upon the nearness of kinship, and disposal is a responsibility of the custodian. The body to which he who exercises the right of custody is entitled, is that of a deceased person without mutilation (an expression of law) and in the state it was at the time of death, unless for medico-legal reasons it passes to the jurisdiction of the coroner or medical examiner, or is under the control of the military services of the Government. Without permission for a postmortem examination by the custodian of the body, his rights are violated and legal redress may be had. The legal custodian then must give consent for the examination. This custodian is a spouse, a parent, a brother or sister, or the nearest of kin. A relative may object to a postmortem on the basis of sentiment, an emotional reaction of great affection against any thought of violating the sanctity of the body and with a failure to understand the constructive purposes of the postmortem; on the basis that it is a mutilation, some form of experimentation, or the satisfaction of a cheap form of curiosity. Pathologists, of course, understand these reactions. To them the postmortem is not a sacrilege, is not a mutilation in the crude meaning of wanton cutting of the body, but rather is a scientific examination conducted with dignity and propriety equal to that of a surgical operation performed on the living. It is fair to say that even the procedures of most

extensive postmortem cannot approach the damage which the disease has already accomplished. Has it not taken the life of your relative or friend?

In some circles, objections on the basis of religious teachings are offered as a reason for not permitting a postmortem. According to Otto Saphir extensive investigation has revealed nothing in the Jewish religion which forbids a postmortem examination, and Oscar Shultz found no prohibition in the Christian religion. At the death of Pope Leo XIII, the newspapers, he stated, carried comments on the postmortem performed by three eminent Italian pathologists. Religion, therefore, is an excuse, not a reason for objection against a postmortem examination among either Jews or Gentiles.

Among the morticians are some who think that the postmortem examination renders more difficult the preservation of the body for the ceremonies of burial; others say that better appearance and preservation of the body are possible after a postmortem examination. With pathologists cooperating in making the external incisions in suitable planes of the body; sparing, ligating and marking the large arteries, these objections are greatly minimized. But in the pathologist's field of practice, just as in surgical procedures of the living, some disfigurement occurs when an external deforming disease is present and is removed for study. Perhaps some objections on the part of the morticians stem from unnecessary or inadvertent delays at the hospital in releasing the body or in completing the death certificate forms.

When a physician makes no effort to obtain, or instructs his resident not to request consent for a postmortem examination he lays himself open to the suspicion, justly or unjustly, that the dead body has some pathology which he, the physician, may not wish to have revealed. No pathologist in serving his function as impartial arbitrator escapes the experience of sharing postmortem with a clinician, medical or surgical, where pathological changes were encountered which in retrospect established faulty diagnosis or treatment. This is a real test of the quality of the physician's character. Does he accept a hard lesson with equanimity and determination to profit; or does he stubbornly resolve not to expose himself further to a similar experience. The education of a physician, says Henry Christian, must be a continual process. In his opinion, the hospital that has few postmortems has a staff that lacks many qualities to be found in the best physician, it lacks the courage to test its diagnostic ability.

During the latter part of the last century and the early part of this, physicians from America went to Europe to obtain the best specialized training. Many studied at Vienna, Berlin, Hamburg, Prague, Munich and other places because these centers had a wealth of postmortem material. This was possible through laws which gave authority for postmortem examinations on the bodies of patients who died in the hospitals. Many of these physicians, trained in a system where clinical diagnoses were checked by postmortem examinations, returned to this country with specialized training and stimulating enthusiasm. They became leaders in their fields of research or practice and developed centers in this country for training younger generations of physicians. The war has destroyed or disrupted many of the medical centers in Europe and now training in specialized medicine is sought in this country by physicians from abroad.

The demands for training in the medical schools of America at present greatly exceed the teaching facilities. The hospitals and universities cannot meet the demands for specialized training. These envious opportunities for instruction and leadership in medicine need constructive support from the laity. A more widespread understanding by the laity of the purposes and advantages of postmortem examinations will reflect advantageously to both the physician and his clientelle. In this way the laity can help constructively in the improvement of the practice and teaching of medicine in our country.—E. F. H.

CORRESPONDENCE



YOUR MENTAL HOSPITALS, "METHOD OF ADMISSION"

Clarification of the method of admission of persons into a state mental hospital may be helpful. The patient, or various members of the family of the patient, frequently seek the physician's advice for Mary or John or Joe, who is not well mentally and needs to go to a hospital. The individual may enter a private institution or one of the state hospitals. There are many excellent private mental hospitals, sanataria and psychiatric units of general hospitals, which have been inspected, approved and licensed under the law as private mental institutions, by the Illinois Department of Public Welfare.

In 1945 the legislature passed the Illinois Revised Mental Health Act in relation to the admision, retention, care and treatment of the mentally ill. It is a legal procedure and, as such, is somewhat involved in technical terms, but the law is a definite advance in method of admission of patients. There are four types of admission, namely:

1. Voluntary admission
2. Commitment as in need of mental treatment
3. Commitment as mentally ill
4. Emergency admission (a temporary measure)

The patient loses his legal rights only under type three, or commitment as mentally ill. A brief description of the four types are listed below.

1. *Voluntary admission.* Any person who is mentally ill or in need of mental treatment may apply directly to the Superintendent of a mental hospital for admission, upon the presentation of a notarized petition. (The petitions are available from the County Clerk.) The petition may be signed by (a) the person seeking admission; (b) the parent or guardian, if the person is a minor; or (c) any relative or attorney, with the consent of the person seeking admission. The voluntary patient does not lose his or her civil rights, and may leave the hospital fifteen days after submitting a written request to the Superintendent of the hospital.
2. *Commitment* as in *need of mental treatment,* and
3. *Commitment* as *mentally ill.* The procedure is similar for both types of commitment. The only difference is a legal one, for under number two, the person does not lose his legal rights, and under number three the individual does lose his legal rights. The com-

mitment is made by the Court. The individual is first examined by a physician, and a signed statement made, stating that the individual is mentally ill or in need of mental treatment. The doctor's statement is then taken to the County Clerk and a petition filed. A date for a hearing is then set by the County Judge. (In Cook County these hearings are usually held at Psychopathic Hospital.) Prior to the hearing, two physicians examine the patient and, acting as a commission, advise the County Judge concerning the patient's mental condition. At the hearing, the patient may be discharged, or committed to a private or a state mental hospital, or to the veterans' facilities.

4. *Emergency admissions.* This provides for the emergency admission, to a mental hospital, of a mentally ill person who may be dangerous to himself or to others. This procedure is restricted by law to true emergency conditions, for protection of the patient or the general public. Physicians should exercise due caution and should not recommend admission unless an actual emergency exists. Under this provision, a physician's statement, and a notarized petition obtained from the County Clerk, is presented to the Judge of the County Court. If the Judge is satisfied that the welfare of the patient or the general public requires it, he may issue a writ directing an Officer or the Sheriff to deliver the person to a designated mental hospital. Within fifteen days of admission, this patient will be discharged or legally committed, as described under (2) or (3).

Physicians should exercise due caution in signing statements concerning an individual's mental condition, for they are legally liable. The mental hospitals are, by law, restricted to patients who are mentally ill. Patients with physical disabilities, and without mental illness, cannot be accepted nor retained, and by law must be discharged.

The above is a brief extract of the laws relative to admission of patients to mental hospitals. More detailed information may be found in the Revised Mental Health Act in the Illinois Revised Statutes.

George A. Wiltrakis, M.D.
Deputy Director
Medical & Surgical Service

AMERICAN GOITER ASSOCIATION TO MEET IN MADISON

To the Editor:—

We would appreciate it if you would announce in the section of your Journal devoted to future meetings the time and place of the American Goiter Association. This meeting will be held in the Hotel Loraine, Madison, Wisconsin, May 26th, 27th, and 28th, 1949.

The program for the three day meeting will consist of papers dealing with goiter and other disease of the thyroid gland, dry clinics and demonstrations.

Yours sincerely,
T. C. Davison, M.D.
Corresponding Secretary

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1949 AWARD CONTEST

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1949. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in October of 1949.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving Certificates of Merit, in its Official Publication.

All entries for the 1949 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and must be received not later than April 1, 1949. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

CRIPPLED CHILDREN'S DIVISION LISTS JANUARY CLINICS

The Division of Services for Crippled Children of the University of Illinois will conduct clinics in 19 Illinois cities during the month of January, Dr. Herbert R. Kobes, director announced. The schedule follows:

January

4 — E. St. Louis, St. Mary's Hospital
5 — Joliet, Will Co. TB Sanitarium
6 — Hinsdale, Hinsdale Sanitarium
6 — Cairo, Public Health Building
11 — Peoria, St. Francis Hospital
11 — Quincy, Blessings
11 — Salem, American Legion Hall
12 — Evergreen Park, Little Co. of Mary Hospital
12 — Alton, Memorial Hospital
14 — Chicago Heights, St. James Hospital (Rheumatic Fever Cl.)
14 — Clinton, Y. M. C. A.
18 — Danville, Lakeview Hospital
18 — Peoria, St. Francis Hospital
19 — Sterling, Sterling Public Hospital
19 — Springfield, St. John's Hospital (Cerebral Palsy Cl.)
20 — Rockford, St. Anthony's Hospital
20 — Normal, Brokaw Hospital
25 — Effingham, St. Anthony's Hospital (Rheumatic Fever Cl.)
28 — Chicago Heights, St. James Hospital (Rheumatic Fever Cl.)

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which lead to crippling.

Diagnostic clinics are conducted by the Division in cooperation with local medical and health organizations. Private physicians, who are certified Board members, are engaged to make orthopedic and pediatric examinations and to make specific recommendations for care of the individual child.

The Division works cooperatively with local medical societies, Illinois Children's Hospital-School, hospitals, civic and fraternal organizations, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis, and other interested groups.

CRERAR IS LARGEST MEDICAL LIBRARY IN THE MIDWEST

To the Editor:—

In view of a recent conversation I had with you about resources in Illinois for the study of the History of Medicine, it occurs to me that the readers of your Journal might be interested in certain facts about The John Crerar Library. For this reason, I would be pleased if you would find space for this letter in your correspondence columns.

Many physicians make use of our medical collections, but I doubt whether more than a small number of the physicians in the State realize that the John Crerar Library is the largest medical library in the Middle West and that it is interested in serving the medical profession of the whole area. Chartered under the laws of the State of Illinois, the Library does not have the narrow political limitations of most public libraries. It can, in fact, extend the service of its medical department just as widely as its resources will permit. Your readers are all invited to visit the Library whenever they are in Chicago and to avail themselves of the opportunity to borrow materials from us through the facilities of their neighboring libraries.

There are two special items about the Library which I should like to describe, namely, our Medical Union Catalog, and our interest in building up intensive research collections in the several specialties of the medical profession.

With the assistance of the Institute of Medicine of Chicago, a Medical Union Catalog was established in 1933. This catalog records locations of books in seven medical libraries in and near Chicago. We believe it should include records of still other libraries, including private libraries of physicians who would be willing to lend books when they possess a copy of a book not recorded in one of the institutional libraries. Accordingly, we extend invitation to doctors in

this region to let us know by correspondence or through personal visit whether they would wish to participate in such a cooperative program.

We realize that the principal research activities in the field of medicine relate to special diseases such as cancer, infantile paralysis, tuberculosis, or to the specialties such as pediatrics, ophthalmology, cardiology, etc. The Library has particularly strong collections in a number of fields due very largely to the generosity of doctors who have given their private collections to The John Crerar Library. I could describe a number of such gifts, but I will mention only the latest, the gift of Dr. Clifford G. Grulee's library on pediatrics. We think that Crerar is a particularly appropriate home for such collections, because it is a public library and, as such, extends its services alike to all doctors without preference to institutional affiliations.

Sincerely yours,
Herman H. Henkle
Librarian

EXAMINERS MAY EARN RETIREMENT CREDIT

To the Editor:—

We would appreciate your publishing the following item in your Society Bulletin.

"War Department Circular 71, 1947, provides that Reserve Officers who give time to the Selective Service System would, upon certification by the State Director, be given credit toward retirement. For each two (2) medical or dental interviews one (1) hour credit will be given, not to exceed eight credit hours in one day.

Reserve Officers of the Medical Department may be used as advisors to the local induction boards. Selectees who have one or more physical defects, according to Selective Service Regulations, will be sent to an advisor. The advisor will make only such examination as he deems necessary to determine whether or not registrant has any of the disqualifing defects listed in Selective Service Regulations.

It is expected that the number of advisors will be large enough to keep referrals to individual advisors to a minimum.

Reserve Officers interested in the above should contact The State Director, Selective Service System, Illinois State Headquarters, 523 Plymouth Court, Chicago 5, Illinois.

The next meeting of the Medical Reserve Officers will be:

27 October 1948 592 OR Composite Medical Group

8 November 1948 All T/O & E Medical Units

At the present time the Mechanics for promotion of Reserve Officers are being formulated. It is expected that a system will be set by 1 January 1949.

SIGNED: The Medical Instructors
EDWARD W. GILGAN, Captain, MSC

ANNUAL CLINICAL CONFERENCE

The fifth Annual Clinical Conference of the Chicago Medical Society will be held in Chicago at the Palmer House, March 1, 2, 3, and 4, 1949. The scientific program promises to be most outstanding with well-known speakers from all sections of the country discussing subjects which will be of interest to all physicians. Many scientific exhibits are being planned and the technical exhibits will be well displayed.

One of the interesting features of the Conference will be the luncheon round tables when questions will be answered by the speakers.

Physicians of other states and cities are cordially invited to attend this important medical meeting. Reservations should be made direct with the Palmer House.

SALE OF U. S. SAVINGS BONDS IN ILLINOIS

Peacetime sales of series E Savings Bonds in Illinois passed the billion dollar mark this month. Arnold J. Rauen, State Director of the Treasury's U. S. Savings Bonds Division reported that the people of Illinois have purchased $1,018,270,000 of Series E Bonds since the close of the Victory Loan, January 3, 1946.

September E, F, and G sales totaled $39,531,000. Series E accounted for $28,948,000. Series F, $1,534,000, and series G, $9,049,000. E Bonds showed an 11% increase over the same month last year, following the pattern of upturn of the last several months.

"The investment of these large sums has an important influence on both the present and future well-being of Illinois. Creating these reserves relieves pressure on the consumer goods markets and builds a huge stored-up buying power for the future. The total value of E, F, and G Savings Bonds held by individuals in the state is now well over 3½ billions," said Rauen.

ORIGINAL ARTICLES



The Clinical Interpretation of Sternal Puncture

Paul L. Bedinger, M.D., and
Louis R. Limarzi, M.D.
Chicago

The study of the bone marrow has become of great value in the proper diagnosis and prognosis of blood dyscrasias during life. In 1903, Pianese[1] first obtained human bone marrow by puncture of the human femur. In this same year, Wolff[2] trephined the tibia and femur of experimental animals and suggested biopsy of the bone marrow as a clinical procedure. In 1908, Ghedini[3] observed that latent malaria and leishmaniasis could be diagnosed from smears of the bone marrow when the peripheral blood examination was negative. He trephined the upper end of the tibia. Seyfarth[4], in 1923, removed a small piece of sternal bone marrow surgically. This procedure in a modified form is still used today by some hematologists. The first use of the aspiration technique with a needle puncture was done by Arinkin[5] in 1927.

The bone marrow is that portion of the bone which fills the cylindrical cavities of the long bones and occupies the spaces of the cancellous tissue even into the larger bony canals, the Haversian canals, which contain the blood vessels. The marrow of long bones is yellow in color and composed mainly of fat cells, connective tissue supporting numerous blood vessels and a few marrow cells. In the flat and short bones, in the articular ends of long bones, in the bodies of the vertebra, in the cranial diploë, and in the sternum and ribs the marrow is red in color. It contains in addition to cell globulin, nucleoprotein, extractives, salts, connective tissue with blood vessels, a large percentage of marrow cells and only a small amount of fat. The relative percentage of red as against yellow marrow decreases from birth to eighteen years of

Read before the 108th annual meeting of the Illinois State Medical Society, Chicago, June 10-12, 1948.

From the University of Illinois College of Medicine, Department of Internal Medicine.

This study was made possible in part by a grant from Armour & Co., Chicago, Ill.

age. The bone marrow of adult life varies from 1600 to 3700 grams, with only about half of this amount in an active state.

There is some question as to the method of entrance of the mature blood cells into the peripheral blood. One view holds that the red cells are formed within the endothelial spaces and are released intermittently. A second theory is that they are formed extravascularly and enter the blood stream by diapedesis. The granulocytes are formed extravascularly and reach their destination by their own locomotion. The spleen and liver are hematopoetic organs in embryonic life and may assume the same function during adult life in certain blood dyscrasias. The spleen plays a role in blood destruction and pigment metabolism and likely has a humoral effect on the bone marrow.

METHODS

The two methods most commonly used today are the marrow biopsy and the sternal aspiration. The former when done with a sternal needle requires skin incision and yields a specimen which can be used for histologic sections, smears, imprints, and serum suspension preparations. The disadvantages of this method are: 1—it is more painful, 2—it is more difficult to do, 3—there is risk of hemorrhage and infection, and 4—repeat studies are objectionable. The method of marrow aspiration is more simple, offers a diagnosis immediately, and can be repeated as often as desired. It thus has achieved greater popularity. It is carried out in the following manner. With the patient lying on his back on a firm table, the skin over the upper sternum is prepared with tincture of iodine and alcohol. Place the thumb and index fingers of the opposite hand in the second or third interspace parasternally depending on the location chosen for puncture. In children the first interspace is used as a landmark for entering the manubrium. Infiltrate the skin and subperiosteal tissue with 2% procaine solution. With moderate pressure and rotation, a special 16 gauge needle* is caused to enter the marrow cavity perpendicular to the sternum. A sudden give indicates that the marrow cavity has been reached. The stylet of the needle is then removed and a five or ten cc. syringe with a tight fitting barrel is attached. Exactly one cc. of marrow contents is then aspirated and placed in a chemically clean small Wasserman tube containing a few granules of dry heparin†. The tube is gently inverted several times to insure the anticoagulant effect of the heparin. Direct smears are made with the marrow remaining in the syringe. In order to concentrate the marrow cells[6], one cc. of the marrow is transferred into a Wintrobe tube and centrifuged for five minutes at about 2000 R.P.M.'s. The marrow fluid is then separated into four layers — fat, plasma, myeloid-erythoid (containing the megakaryocytes), and the red blood cells. The fat and most of the plasma are aspirated off with a Wintrobe pipette and discarded. The remaining plasma and the myeloid-erythroid layer are then removed and mixed in a clean watch glass from which concentrate smears are then made. The direct and concentrate smears are air dried and stained with Wright's stain for one and a half minutes and then diluted with distilled water or buffer solution are allowed to stain for 18 minutes longer. Larger particles adhering to the tube may be collected and congealed according to the method of Berman and Axelrod[7], or dropped directly into Zenker-formalin solution, from which tissue sections may be made.

The normal myeloid-erythroid layer is approximately 6.8 percent. By use of the concentration technique a direct estimate of the degree of hypoplasia or hyperplasia of the bone marrow can be made. At the same time, since most of the admixture of red blood cells is eliminated, search for unusual cells can be facilitated without disrupting the marrow pattern.

NORMAL BONE MARROW

In the examination of the marrow smear, myeloid elements are in an 8:1 to 2:1 (average 2.75:1) proportion to the erythroid cells. A few megakaryocytes, lymphocytes and monocytes from the admixture with peripheral blood, plasma cells and fat (in the direct smear) may be seen. The predominate cell of the myeloid series is the neutrophilic metamyelocyte with mature neutrophils, neutrophilic myelocytes, promyelocytes, leukoblasts, and reticulo-endothelial cells appearing in successive decreasing frequency. The most common cell of the erythroid series is the polychromatic normoblast with fewer num-

*The "U. of I." needle as modified by the authors may be obtained from V. Mueller & Co. 408 S. Honore St., Chicago 12, Ill.

†Powdered Heparin, Lot Number 153, Hynson, Westcott, and Dunning, Baltimore 1, Maryland. This type of Heparin is inexpensive and one gram will suffice for 350-400 sternal punctures.

bers respectively of basophilic normoblasts, orthochromatic normoblasts, and pronormoblasts. Actual differential counts of the myeloid-erythroid cells are often unnecessary to the experienced observer. Should such be desired a total of 500 cells must be counted. Cells whose morphology has been disrupted beyond recognition, and those in mitosis, should be separately noted. The mean values for the myeloid series of adult marrow are as follows: Myeloblasts, leukoblasts, and promyelocytes 1.3%, neutrophilic myelocytes 10.3%, neutrophilic metamyelocytes 62.3%, neutrophilic polymorphonuclears 23.1%, eosinophils (all stages) 2.5%, and basophils 0.5%. The mean values for the erythroid series consist of pronormoblasts 2.6%, basophilic normoblasts 13.2%, polychromatic normoblasts 78.3%, and orthochromatic (acidophilic) 5.9%. Megakaryocytes number about 52 per 18 mm. square. Children have slightly higher percentages of neutrophils. This tendency is more marked in prematures and the marrow is more hyperplastic and immature. Many more lymphocytes are seen in children than adults due to sinusoidal dilution.

BONE MARROW IN CERTAIN CLINICAL CONDITIONS

1. *Pernicious Anemia and Other Macrocytic Anemias.*

In a pernicious anemia in relapse there is abnormal erythropoesis and granulopoesis. The characteristic cell is the megaloblast which is found in far greater numbers than the pronormoblast of normal marrow. The more severe the anemia, the greater the megaloblastic hyperplasia. The megaloblast differs from the pronormoblast in having a more distinct chromatin network and more parachromatin. It accumulates hemoglobin more rapidly in proportion to the maturity of the cell. It is usually larger in size and is arsenic sensitive, a characteristic not found in most other types of anemia with erythroid immaturity[8]. The larger size and chromatin arrangement of the early megaloblast is likewise seen in the later maturing megaloblasts. In addition to the above evidence of abnormality in the red blood cell development, lobulation and fragmentation of the nucleus with the formation of Howell-Jolly bodies are observed. The abnormal granulopoesis is evidenced by the macropolycytes, the so-called pernicious anemia neutrophil with seven to ten lobes of the nucleus, and large neutrophilic promyelocytes[9] and metamyelocytes. In very rare instances, the degree of abnormal granulopoesis may be greater than the abnormal erythropoesis. Furthermore, after treatment, the abnormal granulocytes are the last to disappear and the first to reappear in relapse. In the peripheral blood the macropolycytes, megalocytic type of anemia, leukopenia, and thrombocytopenia are seen. Within twenty-four to forty-eight hours after intramuscular liver extract or folic acid are administered the megaloblastic marrow is converted into a normoblastic type[10], although megaloblasts and the abnormal granulocytes can still be seen along with the characteristic reticulocyte response peripherally. The marrow thus serves as a guide to the effectiveness of therapy.

Other conditions with a macrocytic anemia and megaloblastic marrow are sprue, nutritional anemias, pernicious anemia of pregnancy, and a megaloblastic anemia of infancy. These likewise respond to intramuscular liver, although Watson and Castle[11] report a nutritional anemia which responds only to oral liver therapy. Unfortunately the authors did not make any bone marrow studies. Achrestic anemia is a rare type of macrocytic anemia with a hyperplastic marrow which is said not to respond to liver therapy. There is free hydrochloric acid and an absence of glossitis and cord changes are evident in spite of the megaloblastic marrow. The macrocytic anemia associated with a normoblastic marrow seen in cirrhosis of the liver, aplastic anemia, leukemia, hemolytic anemia and others do not respond to liver or folic acid. The need for sternal puncture to differentiate these latter conditions is therefore apparent. The finding of a megaloblastic bone marrow in pregnancy with a macrocytic, normocytic or microcytic and hypochromic anemia in the peripheral blood is rare[12]. A diagnostic aid in determining a pernicious anemia of pregnancy in the peripheral blood in the absence of a megalocytic anemia, is the finding of pernicious anemia neutrophils. It is thus well to remember that the marrow will help determine the need for iron or liver therapy.

Primary aplastic anemia may show a hypoplastic or less commonly, a hyperplastic marrow associated with a macrocytic anemia, leukopenia, and thrombocytopenia peripherally. Purpura, leukemia, and agranulocytosis may thus be ruled out by sternal puncture.

2. *Normocytic Anemias.*

Acute post-hemorrhagic anemia, aplastic anemia, simple chronic anemia (renal disease,

malignancy, tuberculosis, syphilis, bacterial endocarditis, hypothyroidism[13]), myelophthisic, physiologic anemia of pregnancy, hemolytic anemias (sickle cell, familial and acquired hemolytic, malaria, poisons, and sulfonamides), are of the normocytic type. In these conditions the marrow shows varying degrees of erythropoetic and granulopoetic activity[14] and megakarycytic hyperplasia or hypoplasia. Mitotic figures are more common. In the hemolytic anemia, the marrow response at its height shows numerous pronormoblasts. In acute hemolytic anemia with marked reticulocytosis the anemia is macrocytic in type. The marrow in all these conditions mentioned is not diagnostic and reliance on other laboratory tests is needed to confirm the diagnosis.

3. *Simple Microcytic Anemia.*

Many of the chronic and subacute diseases mentioned above may be characterized peripherally by a microcytic anemia. The marrow shows varying degrees of myeloid and normoblastic response depending on the disease process.

4. *Hypochromic Microcytic Anemia (Iron Deficiency).*

The nutritional anemias associated with infancy, the anemias associated with alimentary disease and chronic blood loss depict the so called idiopathic hypochromic anemia. The marrow reveals a normoblastic hyperplasia with less increase in the myeloid response unless complicated with secondary infection. Increased numbers of megakaryocytes are present. The hypochromic anemias are usually microcytic. These abnormal findings are corrected with iron medication.

5. *Enlargement of the Lymph Nodes and Splenomegalic States.*

Infectious states with or without lymphadenopathy or splenomegaly show varying degrees of granulopoetic activity of the marrow. A so called shift to the left, with greater numbers of immature cells is seen.

Infectious mononucleosis may show a normal or occasionally some increase in granulopoesis on marrow examination[15]. However any suspicion of leukemia may be ruled out by sternal puncture.

There is nothing diagnostic in the marrow study of Hodgkin's disease. Some increase in the cosinophilic granulocytes, megakaryocytes, plasma cells and histiocytes may be encountered along with a generalized hyperplasia. Some authors feel they can detect Sternberg-Reed cells in marrow sections and smears, but detection of these is at present difficult and uncommon. A gland biopsy is needed to confirm the diagnosis[16].

Hyperplasia of the granulopoetic series is to leukemic states as erythropoetic activity is to pernicious anemia. In some instances the marrow only mirrors the changes observed in the peripheral blood. However in the subleukemic states and in leukemoid reactions, marrow examination is of definite value in the differential diagnosis. The acute forms of leukemia- myelogenous, lymphatic, monocytic, plasma cell type (a variant of multiple myeloma), reticuloendotheliosis, and perhaps megakaryocytic — are characterized by the presence of the respective inmature cell in large numbers in the marrow. In some instances due to the abnormal morphological characteristics, a diagnosis of undifferentiated or stem cell leukemia is justified. The Schilling type of monocytic leukemia shows great variation in cell size and may or may not contain azurophilic granules within the cell. Many reticulo-endothelial cells may accompany these monoblasts. The Naegeli type of monocytic leukemia is thought by some observers to be a variation of myelogenous leukemia as there is a tendency for the early myelogenous cells to differentiate along monocytic lines and difficulty in accurately classifying these types is noted. The sub-leukemic or leukopenic leukemias often show a normal peripheral smear but examinations of the marrow will reveal the characteristic cell types. This is more common in the leukemia of children than that seen in the adult. These forms are almost always acute leukemias.

The subacute leukemias are those which run a more prolonged course but present the marrow picture of an acute leukemia.

The chronic leukemias are often diagnosed on peripheral blood examination but a study of the marrow will reveal a hyperplasia of the respective leukemic cells and most often an increase in the number of immature forms.

Some difficulty is encountered at times in differentiating a leukemoid reaction from a true leukemia. In a leukemoid reaction the peripheral blood shows a leukocytosis and basic granulation of the neutrophils which may offer some help in the diagnosis. The marrow in the leukemoid reaction does not show the focal masses of cells typical of leukemia and these

immature cells are more normal in appearance than the leukemic varieties. Again, the granulocytes of the marrow have toxic granulations and other degenerative changes in the leukmoid states less commonly seen in leukemia. However the diagnosis is at times difficult and repeated observations will be necessary[17].

The bone marrow in polycythemia vera is often entirely normal but on occasions increased numbers of normoblasts may be seen or a general hyperplasia of all marrow elements.

Early in Banti's syndrome[18], anemia and leukopenia are not severe, and marrow films will show only a myeloid hyperplasia. Later a 'maturation arrest' develops and an increase in the per centage of neutrophilic myelocytes in the marrow with marked peripheral neutropenia. At this stage splenectomy will restore the peripheral blood picture to normal. Later, when cirrhosis of the liver is evident, a marked erythroid immaturity and increase in the megakaryocytic tissue of the marrow is noted with a peripheral thrombocytopenia. At this stage splenectomy is of no value.

In Felty's syndrome[18] when associated with enlargement of the lymph nodes, spleen and anemia with chronic arthritis, the bone marrow findings are similar to Banti's syndrome without cirrhosis of the liver. The result of splenectomy is transient although spectacular. In primary splenic neutropenia, a condition associated with fever, pain and enlargement of the spleen with granulocytopenia, and in primary splenic panhematocytopenia[19], characterized by anemia, thrombocytopenia, and granulocytopenia, the marrow may be normal or somewhat hyperplastic. Before splenectomy is contemplated in these conditions, it must be determined that one is not dealing with a hypoplastic marrow. Splenectomy is contraindicated with the latter finding.

6. *Essential Thrombocytopenic Purpura*[21].

The type most commonly referred to in this disease is characterized by an increase of the megakaryocytic tissue of the marrow associated with thrombocytopenia in the peripheral blood. These megakaryocytes are often abnormal or inmature. Associated with the megakaryocytic increase, if bleeding is present, is a normoblastic reaction and at times myeloid hyperplasia. In this form of the disease splenectomy is indicated. A second variety of essential thrombocytopenic purpura, referred to as the aplastic type, shows a marked hypoplasia to absence of megakaryocytes and the disease runs an acute course. Splenectomy is 70-80 percent fatal.

In secondary or symptomatic thrombocytopenic purpura, the bone marrow pattern varies with the underlying cause. Thus the acute and chronic leukemias, aplastic anemia, multiple myelomas, or metastatic carcinoma, infectious and various chemical, vegetable, animal and physical agents such as x-ray, may produce a decrease or abnormality in the megakaryocytic tissue with thrombocytopenia peripherally. Again, splenectomy is contraindicated. In hemophilia the megakaryocytic tissue during life appears normal[21].

7. *Granulocytopenia (Agranulocytosis*[22]).

There are two types of granulocytopenia, the so called 'maturation arrest' and the aplastic type. These may be idopathic or they may be secondary to drugs, gold, sulfonamides, thiouracil, X-ray or radium, and certain infections. In the 'maturation arrest' type, the myeloid series of the bone marrow is normal or may show increased numbers of neutrophilic myelocytes and their precursors, but a marked reduction or absence of later forms. It is this condition which properly is termed agranulocytosis and offers the best hope of recovery. In the aplastic type in which all of the granulocytes disappear and an increased percentage of lymphocytes are seen in the marrow, death follows. It is thus imperative from a prognostic viewpoint to carry out a sternal puncture procedure.

8. *Lupus Erythematosis Disseminata*[23].

In some cases of this disease, two types of cells are found which offer help in the diagnosis. The first is called a 'tart' cell and is found in lymphoblastoma, pulmonary infection and metastatic carcinoma as well. It is described as being a histiocyte or monocytoid reticuloendothelial cell although in our limited experience, polymorphonuclears are commonly involved. These tart cells are characterized by a secondary nucleus which stains reddish purple with Wright's stain and is placed in the Hof of the primary nucleus. The second cell found in this disease occasionally is the 'L.E.' cell. This cell is practically always a mature neutrophil and is characterized by a large digestive vacuole within the cell membrane.

9. Miscellaneous Conditions:

The bone marrow study is of value in a number of other disease processes. In metastatic carcinoma and multiple myeloma one may find the characteristic tumor cells. Gaucher's disease, Niemann-Pick's disease, neuroblastoma, histoplasmosis and Kala-azar all offer specific diagnostic cells. In malaria, the parasites may be found in the marrow although not detected peripherally. Sternal biopsy may be of value in differentiating myelosclerosis and/or myelofibrosis from leukemia and other conditions.

The negative value of sternal puncture is large and perhaps is of greatest value in cases in which the examination allows one to reassure patients who were thought to be seriously afflicted.

Finally a word as to the proper use of sternal puncture. This procedure is an adjunct to diagnosis and as seen may alone lead to the proper evaluation of the prognosis and diagnosis. However the careful history, physical examination, and complete peripheral blood examination should first be done. Then if a diagnosis is not available, a sternal puncure may be indicated. Even then in inexperienced hands, a dry tap or improper aspiration may lead to an incorrect diagnosis.

1853 W. Polk Street.

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The Present Management of Peptic Ulcer

Joseph B. Kirsner, M.D.
and
Walter Lincoln Palmer, M.D.
Chicago

The objective of therapy in peptic ulcer is protection of the mucosa from the digestive action of acid gastric juice. Ideally, this might be accomplished by improving the resistance of the mucosa or by permanently inhibiting the secretion of hydrochloric acid. Since no methods are available for these purposes, chief reliance at present, as in the days of Sippy, is placed in measures designed to neutralize or effectively reduce the output of acid.

The program to be outlined emphasizes principles of therapy; in no other disease, however, is it more important to adapt the treatment to the particular circumstances of the individual. Therapy must be prolonged, not only to ensure complete healing of the ulcer, but also to lessen the possibility of recurrence.

Rest. — Rest, including relief from all mental as well as physical strain, is most important. Clinical and experimental observations in man indicate that emotional disturbances, such as prolonged anxiety, resentment or hostility, increase the secretion of acid gastric juice and possibly the susceptibility of the mucosa to ulceration. The degree of rest required by the individual patient varies; some rest better while continuing at work or on a fishing trip than they do in the hospital. Nevertheless, hospitalization for a period of two or three weeks has many advantages. Relief from emotional stress and insecurity is essential, yet often difficult to accomplish. The sympathetic and encouraging attitude of the physician is particularly helpful in this regard. The use of mild sedatives, such as phenobarbital (0.03 gm.) during the day and seconal (0.09 gm.) at night, promotes relaxation and sleep.

Diet. — The diet, during the first two or three weeks of treatment, consists principally of whole milk and 18 percent cream, taken as an equal mixture in quantities of 3 to 4 ounces, hourly from 7 a.m. to 7 p.m. Malt, chocolate, or skimmed milk powder may be added if a gain in weight is desired, or the mixture may be replaced by skimmed milk, if the patient is obese. Additional feedings are instituted early in therapy and increased every one or two days until 6 are being taken. The feedings are selected from the following group: cream of wheat, farina, boiled rice, soft boiled eggs, toast, butter, cream, custard or cornstarch pudding, jello and ice cream; strained fruit juices are allowed as desired. In patients with moderate stenosis, a 3 feeding schedule may be maintained to advantage for several weeks. The so-called three meal program is instituted during the second or third week of treatment; the details of this schedule are as follows:

8:00	Breakfast	2:30	Antacid
8:30	Antacid	3:00	Milk and cream
9:00	Milk and cream	3:30	Antacid
9:30	Antacid	4:00	Milk and cream
10:00	Milk and cream	4:30	Antacid
10:30	Antacid	5:00	Milk and cream
11:00	Milk and cream	5:30	Antacid
11:30	Antacid	6:00	Supper
12:00	Dinner	7:00	Antacid
1:00	Antacid	8:00	Antacid
1:30	Antacid	9:00	Antacid
2:00	Milk and cream	9:30	Aspirate stomach

The following diet may be used:

Breakfast

1 Serving of:	Egg (1 or 2)
Fruits	Soft boiled
Orange juice	Soft poached
Peach purée	Scrambled with milk and butter
Applesauce	
Baked apple (no skin)	1 or 2 slices of toast and butter
Prune purée	1 cup of coffee
Pear purée	1 cup of tea
Apricot purée	1 cup of Sanka
	1 cup of chocolate
Cereals	
Cream of Wheat	
Oatmeal (well cooked)	Cream and sugar as desired
Boiled rice	

Presented before the 108th Annual Meeting of the Illinois State Medical Society, Chicago, May 10-12, 1948.

Frank Billings Medical Clinic, Department of Medicine, University of Chicago.

Dinner

Soups (strained cream soup)
- Rice
- Pea
- Potato
- Celery
- Spinach
- Lettuce
- Asparagus
- String beans
- Tomato
- Carrots

1 Serving of:
- Baked potatoes
- Mashed potatoes
- Rice
- Spaghetti
- Macaroni
- Noodles
- White or whole wheat bread, rolls or biscuits

Vegetables, strained or puréed or cooked until soft
- Carrots
- Beets
- Asparagus
- Green beans
- Peas
- Squash
- Spinach

Meat: 1 small serving of:
- Roast chicken
- Stewed chicken
- Broiled whitefish
- Scraped beef
- Minced beef or diced beef with gravy
- Small portion of roast Lamb, Beef or Mutton
- Broiled steak and lamb chops may be taken after two or three months; (should be thoroughly masticated)

Desserts: 1 serving of:
- Bavarian cream
- Lemon sponge
- Grape sponge
- Blanc mange
- Cornstarch pudding
- Tapioca custard
- Vanilla custard
- Ice cream
- Sponge cake
- Angel cake
- Lady fingers
- Arrowroot cookies
- Vanilla wafers
- Plain cake
- Jello with whipped cream
- Caramel custard
- Cheese

Supper

Cream soup (see noon list)
Rice *or*
Cream of Wheat *or*
Soft egg

Crackers *or*
Buttered toast

Desserts (see noon list)

The patient is expected to follow the program for a year or more, reporting at approximately monthly intervals for such changes as may be indicated.

Amino Acids. — The use of protein hydrolysates has been recommended in recent years for the purpose of increasing the neutralization of the gastric acidity and for the correction of alleged protein deficiencies. There is little convincing evidence, however, that amino acid mixtures significantly improve the neutralization obtained by the usual ulcer diet and by antacids. The intake of protein on the three-meal program is quite adequate. Furthermore, the ulcer patient is capable of digesting and utilizing whole protein as efficiently as the normal person. There would appear to be no significant indication, therefore, for the addition of protein hydrolysates to the diet.

Tobacco. — The immoderate us of tobacco probably should be discouraged on general principles. Excess smoking is a reflection of increased nervous tension. The important problem, therefore, would seem to be the relief of the emotional stress. It may be noted also that many ulcer patients have never used tobacco.

Antacids. — A wide variety of antacids are available for the neutralization of the gastric acidity. The most effective, in our experience, is calcium carbonate, administered in doses of 2 or 4 grams every hour, from 7:30 a.m. to 7:30 p.m. and at 8:00, 8:30 and 9:00 p.m. It is relatively insoluble and does not cause alkalosis. Constipation may result, but it is easily controlled by the substitution of 2 to 10 grams of magnesium carbonate daily. The alkali is continued usually on a two-hour schedule after the ulcer has healed completely. Aluminum hydroxide, magnesium trisilicate and tribasic calcium or magnesium phosphate are satisfactory antacids, although less efficient than calcium carbonate. Mucin, because of its objectionable taste and limited neutralizing property, now is rarely used. The anion exchange resin, amberlite IR-4, does not appear to have any significant advantage over the less expensive antacids.

The administration of milk and cream and alkali as a continuous drip through an indwelling latex rubber tube constitutes an effective means of controlling the gastric secretion. A total of 3000 cc. usually is given in 24 hours. This method of treatment seldom has been necessary in our experience.

Gastric Aspiration. — Nightly aspiration of the stomach with an Ewald tube at bedtime is indicated in patients with evidence of stenosis. The procedure is of value in that it removes a considerable amount of acid gastric content which would otherwise continuously bathe the ulcer. It is discontinued when less than 4 or 5 ounces are obtained. Continuous aspiration during the night with Wangensteen suction frequently is helpful in cases with an excessively high gastric

secretion. With any form of continued gastric aspiration, it is necessary to replace the chloride removed, by the daily oral administration of 4 to 6 grams of ammonium or sodium chloride. Hypochloremia may be treated by the parenteral injection of 2000 to 3000 cc. of isotonic saline solution or 500 cc. of 2 percent ammonium chloride in distilled water. The quantity of salt and fluid to be administered is best determined by frequent measurements of the serum electrolytes. A useful clinical guide, when such analyses are not obtainable, is the daily output of chloride in the urine for which simple tests are available.

Inhibitory Drugs. — Atropine and atropine-like compounds are often used presumably to decrease the volume of gastric secretion and to relieve spasm about the ulcer area. However, neither of these actions has been adequately demonstrated to occur in man. Doses of 0.0005 mgm. of atropine four times daily may be beneficial, however, in that by delaying gastric emptying. the action of the antacid is prolonged and, hence, more effective. Larger quantities produce dryness of the mouth, blurring of vision, and, occasionally, psychotic reactions. The antihistamine drugs available at present do not affect gastric secretion significantly. The detergent, sodium alkyl sulfate, markedly inhibits peptic activity in vitro, but it is not effective in man, even in large amounts.

Hormones. — The treatment of peptic ulcer by various hormones remains in the experimental stage. Enterogastrone, an extract prepared from the duodenal mucosa of hogs, may temporarily inhibit gastric secretion in man when injected intramuscularly in large quantities. Encouraging results in the prevention of recurrences among patients with chronic peptic ulcer have been reported, but a more prolonged period of observation and study seems necessary. A variety of extracts obtained from the urine are under active investigation and their clinical value has not yet been established.

Roentgen Irradiation of the Stomach. — Roentgen irradiation of the stomach, for the purpose of inhibiting gastric secretion, has proved of value in many cases. Approximately 1800 roentgen units are directed, in divided doses, to the fundus and body of the stomach, over fluoroscopically outlined anterior and posterior portals. Unfortunately, the effect is somewhat variable and the resulting suppresion of secretion usually is temporary. However, healing of the ulcer invariably occurs if a complete histamine-anacidity is produced.

Gastric Ulcer. — Opinions differ as to whether the treatment of gastric ulcer should be medical or surgical. The disagreement arises because of conflicting views regarding the possibility of malignant transformation of ulcer and because of doubt as to the accuracy of clinical differentiation of the two lesions. In our judgment, no convincing proof of neoplasia in a preexisting benign gastric ulcer has been presented. However, differentiation of benign and malignant gastric ulcer always is hazardous. Medical treatment should be undertaken only when the evidence in favor of a benign process is very great and when the course of the lesion can be observed very carefully, objectively, by X-ray and by gastroscopy.

Massive Hemorrhage. — The treatment of massive hemorrhage includes absolute bed rest and sedatives for restlessness. Transfusions of whole blood in quantities of 500 to 600 cc. are highly valuable and should be repeated as often as necessary to maintain the blood pressure above shock levels and the erythrocyte count above 3 million. If the patient is vomiting, food and drink are withheld until the vomiting subsides. In the absence of nausea, feedings of milk and cream and alkali, hourly during the day and every two hours during the night, are preferable to starvation. This regimen is maintained until the feces are negative for occult blood for several days. The treatment subsequently is similar to that outlined previously for uncomplicated peptic ulcer. The possible need for surgery must constantly be kept in mind, however, especially in patients 45 years of age or older, with persistent severe bleeding from an eroded arteriosclerotic artery. If the decision is made in favor of surgery, the procedure should include ligation of the bleeding vessel; this may be impractical or impossible in certain instances, in which case a gastric resection may be performed. Gastoenterostomy alone is of little value. Surgical treatment, during an interval between episodes of bleeding, may be desirable, also in patients with severe hemorrhages, recurring despite careful medical management.

SURGICAL TREATMENT

Approximately 10 to 15 percent of patients with peptic ulcer eventually require surgery, primarily for the complications, rarely for the lesion itself.

Acute Perforation. — The most urgent indication for surgery in peptic ulcer is, of course, acute perforation.

Stenosis. — The most frequent indication for surgical treatment in peptic ulcer is stenosis. The obstruction in many patients with clinical evidence of stenosis is due to inflammatory edema and spasm about the ulcer, rather than to cicatricial contraction and usually subsides within 7 to 10 days of medical management, the improvement being manifested clinically by a decreasing quantity of aspirated gastric content and by the maintenance or increase in weight. The indications for surgery are: persistent vomiting, the continued loss of weight, the nightly aspiration of 800 to 2000 cc. of gastric content, visible gastric peristalsis, and the fluoroscopic demonstration of a large dilated stomach with narrowing of the pyloric or duodenal lumen to 3 mm. or less. The procedure of choice at present is transabdominal vagotomy and posterior gastroenterostomy. Partial gastrectomy is preferred by many surgeons; however, ulcers recur in at least 10 percent of patients with duodenal ulcer, treated by resection, and they are much more resistant to therapy than the original lesion.

Gastric ulcer. — The chief indication for resection in the management of peptic ulcer is the inability to differentiate a benign from a malignant gastric ulcer. The difficulty arises primarily because peptic digestion of a gastric carcinoma may produce in such a lesion the architecture of a benign process. Complete relief of symptoms and healing may occur during antacid therapy, thus increasing the deception. Partial gastrectomy is advisable if the nature of the lesion remains in doubt after 3 to 6 weeks of careful treatment in the hospital. In contrast to duodenal ulcer, recurrences are very rare after resection of a benign gastric ulcer, due undoubtedly to the low rate of secretion and the consequently higher incidence of postoperative anacidity.

Jejunal Ulcer. — The medical treatment of jejunal ulcer is difficult, because of the marked tendency of the lesion to perforate and bleed. Surgery usually is preferred, and it is in this group of cases that vagotomy has yielded particularly impressive results. Some patients do respond quite well, however, to medical management alone.

Vagotomy. — Transabdominal vagotomy, combined with posterior gastroenterostomy, represents the most important advance in the surgical treatment of peptic ulcer in recent years. The procedure is safe and relatively simple, although a complete vagotomy is not always possible. Gastric retention and diarrhea occur not infrequently, but they have not constituted troublesome complications in the series reported by Dragstedt. The operation is indicated chiefly in the treatment of cicatricial stenosis and jejunal ulcer. Simple vagotomy may be indicated in patients with duodenal ulcer without marked stenosis who, for some reason, do not respond satisfactorily to careful medical management. In our experience, this is a very small group. The prompt relief of pain and healing of the ulcer are due primarily to the marked reduction in the output of acid and probably also to the diminished motility and tonus of the stomach. Inasmuch as patients with ulcers of the stomach, in contrast to duodenal ulcer, secrete either normal or less than normal amounts of hydrochloric acid, vagotomy, on physiological grounds, does not appear to be indicated in the management of gastric ulcer. The procedure, in our opinion, is not indicated in the treatment of uncomplicated peptic ulcer.

SUMMARY

The fundamentals of ulcer therapy today are essentially the same as those emphasized by Sippy and others more than thirty years ago. There continues to be no procedure, medical or surgical, with the exception of total gastrectomy, that regularly produces complete and permanent anacidity; hence, there is no procedure which regularly leads to cure of the disease. The majority of cases, nevertheless, are benefited by a program of physical rest, relief from emotional stress, and continued neutralization or inhibition of the gastric acidity. Perhaps the most important principle of medical therapy is "the care of the man as well as his stomach". Surgical treatment is indicated in 10 to 15 percent of cases for the complications of peptic ulcer. Partial resection is reserved for those

gastric ulcers in which the possibility of carcinoma cannot be excluded. Transabdominal vagotomy and posterior gastroenterostomy are indicated principally in stenosing duodenal ulcers. Jejunal ulcer is best treated by vagotomy alone.

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Delay in Treatment of Cancer*

Faye E. Bates, M.A. and Irving M. Ariel, M.D.†
Veterans Administration Hospital
Hines, Illinois

Inasmuch as time is an essential element in effective treatment of cancer, a study was made of patients admitted to Tumor Service at the Veterans Administration Hospital at Hines, Illinois, to determine, first, if they experienced delays in securing definitive treatment, and if so, why delays occurred.

This study was based on interviews with all patients admitted to the three wards reserved for tumor patients only during July, August, and September, 1947, whose first admission for treatment of malignant tumor followed June, 1946. The definitions of "delay" and "criticisms" of the first doctor consulted, used by Pack and Gallo in their study published in 1938 have been employed with some modification. The total number of these patients included 119 who proved to have malignant tumors and whose histories form the basis of this study; 34 who were not proved to have malignant tumors, and 21 who could not be interviewed. Of the 119 patients, 64 received their first definitive treatment at Hines, 25 under the supervision of private doctors, 12 in Army or

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†Faye E. Bates was Social Worker and Dr. Ariel was Chief of Tumor Service, in 1947. Dr. Ariel classified the types of tumor and advised the writer as to acceptability of treatment.

TABLE 1

Interval from Onset of First Symptoms to Date of First Definitive Treatment

Interval	Total		Patients who went to 1st doctor within 3 mos. of onset of symptoms.		Patients who did not go to 1st doctor within 3 mos. of onset of symptoms.	
	Number	Percent	Number	Percent	Number	Percent
Total	119	100%	77	100%	42	100%
Under 3 months	23	19.4	23	29.8	0	0.0
3 mos. under 6 mos.	26	21.9	17	22.1	9	21.3
6 mos. under 9 mos.	19	16.0	14	18.2	5	11.9
9 mos. under 12 mos.	9	7.6	7	9.1	2	4.8
12 mos. under 15 mos.	10	8.4	3	3.9	7	16.6
15 mos. under 18 mos.	4	3.3	2	2.6	2	4.8
18 mos. under 21 mos.	4	3.3	2	2.6	2	4.8
21 mos. under 24 mos.	1	0.8	0	0.0	1	2.4
24 mos. under 27 mos.	2	1.7	0	0.0	2	4.8
27 mos. under 30 mos.	2	1.7	1	1.3	1	2.4
30 mos. under 33 mos.	1	0.8	1	1.3	0	0.0
33 mos. under 36 mos.	4	3.3	2	2.6	2	4.8
Over 36 mos.	7	6.0	2	2.6	5	11.9
All dates not recalled	3	2.5	0	0.0	3	7.1
No definitive treatment	4	3.3	3	3.9	1	2.4

Navy Hospitals, 10 in other Veterans Administration hospitals, and 4 in county or State University hospitals, and 4 could not be given definitive treatment because of the advanced state of the disease.

It will be recalled that the definitions used by Pack and Gallo were as follows:

"Delay on the part of the patient is designated as *reasonable* when the time elapsing between the onset or discovery of symptoms and the first visit to a physician is under three months; as *undue delay* when this interval is three months or over. *Subsequent delay* includes refusal to accept the physician's advice, as well as a few cases without frank refusal but with undue delay after consulting the physician which brings the total delay from onset of symptoms to a visit to the clinic beyond the three months period.

"After a patient seeks medical advice the responsibility is shared. A month is considered ample time for a physician to make a diagnosis or refer the patient to a clinic. The time elapsing between the first visit to a physician, however, and the first clinic visit is not a criterion for evaluating the physician's part. Patients may delay still further. On the other hand, the first physician may be open to criticism and the patient may consult a second physician and report to the clinic within a month. Since the word delay may seem to over-emphasize the time element, which is not always significant, the word *criticism* is used in the evaluation of the physician's responsibility. . . .

"The criticisms are classified according to five types of error — (1) wrong treatment, (2) wrong advice, (3) no treatment and no advice, (4) acceptable treatment but with delay in referring when no improvement results, and (5) inability to diagnose within a month. The latter implies observation without treatment."

It will be noted that the interval of three months used by these authors covered the period from the onset or discovery of symptoms to the date of first visit to the clinic; in this study the interval extends to the date definitive treatment (surgery or irradiation) was instituted. This change seemed desirable since it appears necessary to include the interval required for diagnosis by the doctor, clinic, or hospital which provided treatment as well as the time required by the first physician consulted. This alteration is significant in those cases which are difficult to diagnose or to treat definitively. Delay on the part of a patient in following recommendations of the first doctor consulted has been defined as a waiting period of one month or more.

It will be seen from Table 1 that only 23 or 19.4 percent of patients received definitive treatment within 3 months, the period considered "reasonable." Forty-two or 35.3 percent of the patients waited 3 months or more to see a doctor

TABLE 2

Factors which Accounted for Delays in Securing Definitive Treatment within 3 Months of Onset of Symptoms by 96 Patients.

Factors causing delays	Instances	
	Number	Percent
Total	168	100.0%
Patients failed to go to first doctor within 3 months of onset of symptoms	42	25.0
First doctors consulted gave inadequate care	52	31.0
Patients failed to follow recommendations of first doctors consulted	11	6.6
Medical and administrative procedures in making diagnoses and treatment plans caused additional delays	54	32.1
Advance state of disease prohibited definitive treatment	4	2.4
Exigencies of war prohibited prompt treatment	5	2.9

and so experienced "undue delay"; 5 of these patients failed to follow within 1 month recommendations of the first doctor consulted.

Fifty-four or 45.4 percent of the patients went to a physician within 3 months of onset of symptoms but failed to receive definitive treatment within that period. Six of these patients failed to follow within one month recommendations of the first doctor consulted which contributed to "subsequent delay."

The analyses of all causes for delays, shown in Tables 2 and 3, include those caused by patients, physicians, and administrative procedures.

No analysis has been attempted of causes for delays by patients who knew that the medical care they had received was ineffective but who failed to take steps to secure adequate treatment. Doubtless the same factors mentioned in Table 2 and 3 operated also in these cases as some of the patients discussed their reasons for such delays.

Applying the "criticisms" to the services provided by the first physicians consulted the results shown in Table 4 were secured. It will be observed that the most common single criticism of the first doctor consulted is the continuation of ineffective treatment for a period in excess of one month, after which the physician may or may not have assisted the patient to secure more adequate medical care.

The 54 cases which presented problems in making diagnoses and treatment plans included 21 cases in which the patients went to outlying Veterans Administration Hospitals for diagnoses and were transferred to Hines for definitive treatment. The time intervals which were considered in analyzing delays include periods in which patients awaited reports from x-ray and laboratory examinations, appointments with consultants, or hospital beds, or in which they went from doctor to doctor seeking help.

TABLE 3

Reasons for Delays Given by 48 Patients*

Reasons	Total	Delays Before consulting a doctor	Delays After consulting a doctor
Total	63	46	17
Ignorance of seriousness of condition	43	39	4
Ignorance of availability of Veterans Administration and other resources for care	3	1	2
Resistance to doctors or hospitalization	7	6	1
Pressure of business or school	6	0	6
Family responsibilties	1	0	1
Desire to return to civilian life	2	0	2
Substitution of patient's plan for doctor's plan	1	0	1

*This includes 42 patients who did not go to first doctor within 3 months and 6 patients who failed to follow recommendations of first doctor though they went to the first doctor within 3 months of onset of symptoms.

TABLE 4
Evalution of Services Provided by First Physicians Consulted

"Criticisms"	Cases	
	Number	Percent
Total	119	100.0%
Physicians provided definitive treatment or referred patients within 1 month	53	44.6
Physicians provided acceptable treatment but delayed referral when no improvement resulted within 1 month	33	27.7
Physicians "criticized" for other reasons (wrong treatment, wrong advice, no treatment and no advice, no treatment and no diagnosis within 1 month)	33	27.7

These cases represent a wide range of physicians and hospitals including some with outstanding reputations, and many of which have little in common except that for some reason our patients who sought their help did not receive definitive treatment within a "reasonable" period.

Twelve of the 23 patients treated within 3 months were treated by the first physicians consulted; these 12, or 10.1 percent of the entire group, were the only patients given definitive treatment by the first physicians consulted. The preponderance of cases in which patients consulted two or more doctors to secure definitive treatment either by referral of the first doctors consulted or upon their own initiative emphasizes the importance of close coordination of diagnostic and treatment services. Furthermore, it indicates that any study of delays for which the patient and first doctor only were responsible gives a limited analysis of the problems faced by patients who seek treatment and the medical profession which provides it.

Location of cancers in the body has been found by Leach and Robbins to be significant in studying the reasons for delays in securing treatment on the part of patients and making diagnoses and providing treatment on the part of physicians. The analysis of delays, in Table 5, places all responsibility upon the medical profession for delays subsequent to the patient's first consultation with a physician.

It appears that cancer of the lungs presents a difficult problem as none of the 18 patients with this diagnosis received definitive treatment within 3 months although all but 5 of them consulted a physician within 3 months of onset of symptoms. The 9 patients with cancer of salivary glands present a similar picture.

Some examples of case histories may clarify further the problems involved.

One patient went to a doctor in the military service within one month after his diarrhea began and was given pills. Eight months later another doctor in the military made an x-ray examination. Five months

TABLE 5
Site of Cancer as a Factor in Causing Delay in Securing Definitive Treatment*

Site of Cancer	Patients given definitive treatment	Patients treated in 3 mos. of onset	Patients failed to confer with doctor within 3 mos. of onset	Medical Profession failed to provide treatment in 3 mos. of 1st application	Patients & medical profession each delayed 3 mos. or more	Unclassified
Total	115	23	41	69	21	3
Intra-oral	29	7	9	15	3	1
Gastro-intestinal	20	4	6	13	4	1
Lung	18	0	5	14	2	1
Genital-urinary	10	3	4	5	2	0
Salivary glands	9	0	4	9	4	0
Skin	8	2	5	5	4	0
Miscellaneous	20	7	8	8	2	0

*The tabulations are, obviously, not mutually exclusive.

later the patient consulted 4 private physicians, 1 of whom made no recommendation, 2 of whom prescribed pills, and 1 of whom had a laboratory examination made of a sample of feces on which the report was negative and no treatment was advised. During this time the patient applied for admission to a Veterans Administration hospital and received no response. The patient then consulted the seventh physician who proctoscoped him, took a biopsy, and gave the patient a diagnosis of polyp, advised surgery, and arranged for the patient to come to Hines. Two and one-half years after symptoms were noted by the patient he was operated for adenocarcinoma of the colon. This man was very critical of the medical profession for its lack of forth-right attack on cancer and had no sympathy with the policy of some doctors and hospitals of calling the disease by any name other than cancer.

Another patient noticed that an old lump on his neck was beginnig to grow and one year later, in 1944, consulted a physician. He gave as reasons for delay that he experienced no pain and he could not secure leave from work during the war and thereafter. The patient was a mailman and over a period of 3 years, 6 different doctors on his route advised him casually to go to a hospital. A seventh physician who treated him for pneumonia in January, 1947, inquired about the lump and made no comment. An eighth doctor, to whom the patient went in August, 1947, for a statement to enable him to secure a 90 day leave from work inquired about the lump and made no comment but did accommodate the patient by writing a statement that the man needed a 90 day rest period. Late in September the patient decided to come to Hines and was operated one month later for carcinoma of the salivary gland.

A third patient delayed 10 months in going to a doctor because he was able to continue to work and so did not think his condition serious. He then went to the personnel doctor in the foundry where he was employed, was treated medically for two months and given an x-ray examination; the doctor was unable to make a diagnosis and referred him to a Veterans Administration hospital where he was treated for a non-malignant condition. Four months later the patient returned when a tentative diagnosis of bronchogenic carcinoma was made which was later verified by aspiration biopsy after which definitive treatment was begun.

A fourth patient consulted his physician at once and was given local treatment for hemorrhoids with no advice as to follow-up. Five months later the patient returned to his doctor because of intense abdominal pain and was referred to a proctologist who took a biopsy and arranged for surgical treatment. This man said he delayed returning to his physician because he feared he was in serious condition and dreaded treatment and because he wanted to wait until his oldest child completed high school and could help support the family.

This study has revealed the following problems Definition of "delay" and "criticisms" of doctors used in this report need to be carefully analyzed and evaluated by members of the medical profession if they are to be used further. Perhaps different criteria for delay on the part of patients and physicians should be used with respect to cancers at different sites. Whatever definitions are used should be explained to indicate whether they represent goals, the actual situation in which the medical profession finds itself with respect to diagnostic and treatment services, or some other standard.

In spite of campaigns to educate the public on symptoms of cancer and the importance of early treatment, many persons are still uninformed and seek medical care only when they experience pain, inconvenience, inability to work, or cosmetic disfigurement.

Since the large majority of these patients consulted two or more physicians, it is necessary to coordinate diagnostic and treatment services if patients are to be treated promptly.

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Follow-up Studies of Patients with Pre-Frontal Lobe Lobotomy

Jack Coheen, M.D.
Elgin

Since 1941, 52 patients at the Elgin State Hospital have had bilateral pre-frontal lobe lobotomy performed. The various diagnostic categories and results of surgery are outlined in a recent report by Liebert and Davis who made a study of this group approximately a year ago.

We wish to direct our attention in this study to those cases who are considered to have made a good improvement, emphasizing the manner in which they made their adjustment. We regarded the results as good when the patient was able to readjust to his environment in an effective manner, satisfactory to relatives and to the patient and where there has been a significant sustained remission from the illness. Such results were obtained in 11 patients or 19 per cent of the cases.

In this group there were 9 women and 2 men. Average age at the time of surgery was 36 years. There were 4 cases of catatonic schizophrenia, 3 cases of dementia praecox, undetermined type, 2 cases of manic depressive psychosis, mixed type, 1 case of involutional paranoid psychosis and 1 case of psychoneurosis, mixed type. The average duration of illness in this group at the time of surgery was 5.5 years compared to 7.6 years for those showing fair results and 10.6 years in those showing poor results. This is in keeping with the general rule that better results occurred in those whose illnesses were of shorter duration, although there was considerable overlapping and the duration of illness was not necessarily regarded as a deterrent to lobotomy. It is noted that one patient with good results was mentally ill for 14 years and another for 16 years.

Following surgery, the aggressive and distressing emotionality was interrupted and in its place were varying degrees of placidity and sluggishness. Efforts were made to rehabilitate these individuals as soon as possible and they were encouraged to participate in social and occupational activities. Although the initial increment in improvement was quite dramatic, it was noted that these patients in particular soon arrived at a sustained plateau that was to persist for months and months, in spite of all efforts made toward rehabilitation. Characteristic of this prolonged level of adjustment was their gain in weight, their exaggerated cheerfulness, silliness, self satisfaction, carelessness in dress, fatigability amnesia for surgery and their psychotic experiences and absence of concern and self-inquiry. Orientation, however, was re-established and many expressed the desire to go home and many were discharged at this level of improvement. One husband stated in describing his wife, "she has to be told to do everything like a little girl". In some cases, there were periodic relapses into confusion and apathy; mild epileptic seizures developed in others. Siezures were controlled by anti-convulsive medication.

However, relatives for the most part were quite pleased even with this level of improvement as the patient presented no problem in management, their spirits and appetites were good and many relatives welcomed the absence of friction and discord that so frequently characterized family relationships in the period prior to hospitalization. Another factor seemed to operate favorably in the direction of the patient's welfare. The employment of surgery itself in the treatment of these patients represented something concrete and dramatic to the relatives and they were often given to a furthered sense of participation and active interest that did not exist prior to surgery.

As most of the patients were women, they were soon confronted with various household duties. Shopping, cleaning, cooking, care of children and visiting provided continuous en-

From the Elgin State Hospital.

Presented before the Physicians Associations, Department of Public Welfare, State of Illinois, 108th annual meeting, Illinois State Medical Society, Chicago, May 10-12, 1948.

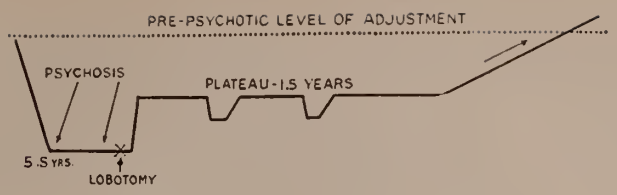


Figure 1. Post-Lobotomy Study. Diagramatic representation of Temporal factor involved in recovery. Figures given are averages for group.

vironmental stimuli that seemed to act slowly, but favorably upon these women and they were found to be able gradually to assume more and more responsibility. The lobotomy seemed to eliminate much of the excessive internal preoccupation and anxieties. The patients seemed to have more energy available for more healthy every-day activities. One happy husband, for example, repeatedly referred to his "new wife."

The feature that we wish to emphasize in this report is the temporal factor in the readjustment of these patients. When seen at the clinics after many months of plateau or partial reintegration as described above, further improvement was regarded as highly questionable. Just when it was thought that they had achieved their maximum adjustment, they slowly but definitely emerged from their retardation and entered a new phase of progress that continues in many cases at the present time. This can be portrayed graphically as in Figure 1.

An example of the type of progress made is the case of M. B. Patient has had several psychotic episodes since 1929, and was considered to be a case of manic depressive psychosis, mixed type. On her last admission, she was frequently combative, screaming, completely out of contact, and was at times a feeding problem. Lobotomy was performed in June 1945. Successive progress notes run as follows:

8/45 — Refuses to dress, untidy in habits.
9/45 — Carelessly dressed, no spontaneity, fatigability.
2/46 — Lack of concern, blandness, carelessness in attire.
4/46 — Suddenly became untidy, incontinent, uncooperative.
9/46 — Showing more energy and some interest in her surroundings, able to do some work in the hospital.
1/47 — Quite pleasant, can be readily stimulated to smile. No anxiety or concern about her future.
5/47 — Remains as above. Neglects bathing.
7/47 — Conditional discharge.
8/47 — Quite silly and laughs readily, helps with housework.
9/47 — Adjusts passively. Eats breakfast, does dishes, sits. Eats lunch, does dishes, sits and rocks, then eats supper, does dishes and goes to sleep.

Several months later, she was induced finally to put in an application at a watch factory where she worked for four weeks and was dismissed because she was unable to get to work on time. Within the past several months, her adjustment has improved considerably and she is now doing clerical work at a hardware company. Her father writes that she has to get up at 6:00 A.M., that she does not complain, is content with her work despite the inconvenience of commuting. She is able to do work around the house more effectively, has a good appetite, is a member of the Methodist Church choir and is active in sports. She seems to display a more pleasant, normal manner with friends and strangers. It is noted that a period of approximately 2½ years following the lobotomy was required before arriving at a reasonably satisfactory and stable level of adjustment.

Case of C. H. was dementia praecox, catatonic type. This patient was a 25 year old, divorced woman who was considered "thoughtful, sweet and lovable, always smiling and laughing, never selfish or jealous and easy to get along with". In 1939, she developed an acute psychotic reaction that was self-limited in nature with recurrence in 1942. For over 2 years, patient was untidy, combative and destructive. Lobotomy was performed October 19, 1945. Progress is as follows:

10/45 — Quiet, no longer disturbed.
2/46 — Had repeated convulsions. Disinterested and unobserving, is tidy, quiet, with little emotional display.
4/46 — Able to work a little, but forgets what she is doing. Collects paper cards and empty candy boxes and keeps them under her bed. Untidy at night.
5/46 — Convulsions.
6/46 — Passively cooperative, shows moderate interest in appearance.
7/46 — Severe convulsions, confused, becomes noisy, paces the floor for hours.
10/46 — Discharged to father.
12/46 — Patient is aloof, superficial and childlike

Case	Age	Diagnosis	Dur	L-D	L-P
		Psychoneurosis			
H.D.	30	mixed	2	1½M	2Y
A.S.	38	D.P. Und.	3	2½M	6M
A.S.	28	D.P. Cat.	3	1M	1Y
K.H.	28	D.P. Cat.	6½	1Y	2½Y
F.K.	39	D.P. Cat.	5	3M	1Y
M.B.	41	M.D. Mixed	16	2Y	2½Y
C.W.	42	D.P. Und.	14		6M
G.H.	39	M.D. Mixed	2	1Y	1½Y
A.E.	57	Inv. Par.	5	4M	1Y
A.K.	32	D.P. Cat.	3½		1Y?
W.S.	26	D.P. Und.	2	1½Y	2½Y
Average	36		5.5Y		1.5Y

Table 1. Post-Lobotomy Study. Patients showing good remissions. (Dur = Duration of illness at time of lobotomy; L-D = Time elapsing from date of lobotomy to date of discharge; L-P = Time elapsing from date of lobotomy to time of emergence from plateau adjustment. Y = years, M = months).

in conversation. Does not work, occasionally helps around the house. Does not argue with brothers as prior to mental illness.

1/47 — Friendly, well groomed, helping mother With housework, goes for walks by herself. Mother pleased.

4/47 — Forgetful at times. Does not read recipe right and puts a cup of milk instead of 3 tablespoons of water in the pie.

4/47 — Enuretic. Doing better at housework.

7/47 — Enuresis stopped. Cannot sustain interest long in conversation. Continues on anticonvulsive.

10/47 — Attempted to work in a candy factory, but was discharged after two days for telling her superior to mind her own business and shut up. Patient appears better and has a boy friend.

4/48 — Employed regularly at a chain company where she assembles skid chains. Has a steady boy friend. Enjoys swimming and fishing. Has no complaints. Mother believes patient is recovered.

Again is noted the long plateau of sluggishness and retardation, but with progressive improvement following discharge. A table indicates the duration of illness, the length of time elapsing from the time of lobotomy to the time of discharge and from the time of lobotomy to the time required to make a good adjustment. (Table 1).

The time needed to effect a good adjustment varies from six months to 2½ years, with an average of 1½ years. This is in contrast to those cases who rapidly effected a good level of adjustment and who were discharged within several weeks to resume their normal daily activity, accompanied by a high degree of optimism on the part of all concerned. Unfortunately, these patients tended to relapse rapidly back into their mental illness requiring periods of hospitalization.

SUMMARY AND CONCLUSION

This is a report on a follow-up study of 11 patients who made a good adjustment following pre-frontal lobotomy. The average duration of illness in this group at the time of surgery was less than for patients who were not able to readjust as well, but there was much overlapping, and duration of illness was not considered a deterrent to lobotomy. The most uniform criterion employed in the selection of these patients for surgery was the existence of continuously distressing emotionality that frequently led to excitement and combativeness. The age range for the group was not essentially different from patients whose response was less favorable. The type of mental illness itself was of little significance.

Among the factors that aided in re-adjustment of these patients was a continued program of rehabilitation, in a favorable and interested environment. Considerable time is needed in many cases before rehabilitation is accomplished, quite frequently involving a period of two years or more. This is a considerably longer period than has been described in other reports of post-lobotomy follow-ups. It is perhaps due to the longer duration of illness in our patients. The number and location of fibre tracts cut is also undoubtedly a factor in determining the eventual out-come. As other investigators have pointed out, improvement is rapid but short lived when incisions were brought too far anteriorly, or involved too few fibre tracts, while too extensive cutting with incisions too far posteriorly left insufficient brain tissue for reintegration.

Successful adjustment in our patients was often preceded by a long period of organic sluggishness and retardation. However, and for this reason, prognosis can not always be determined even after many months of follow-up.

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Mass X-ray Examination Using Miniature Films

Clifton Hall, M.D., M.P.H.
Chief, Division of Tuberculosis Control,
Illinois State Department of Public Health
Springfield

Adequate tubereulosis control has four distinet phases:

1. Case finding
2. Care and Treatment
3. Rehabilitation, and
4. Proteetion of the family against eeonomic stress.

Today we will diseuss a portion of the first phase. Mass x-ray surveys are, in reality, a routine x-ray of certain segments of the population and may be eondueted with either stationary or mobile equipment. Stationary equipment may be loeated in industries, universities, established elinies, or hospitals. Mobile equipment may be mounted in buses or trailers or may be transported in knockdown form and set up at various sites.

The question is often raised about the most satisfactory size of small film for routine survey work. Chamberlin has pointed out that from a sereening viewpoint there is little difference and that the 35 mm., whieh is the smallest size, measuring roughly 1" x 1½", is just as eapable of detecting pathology as the standard 14 x 17. Survey equipment is largely made up of photoroentgen units 35 mm., 70 mm. and 4" by x 5" film either as single exposures or as stereos. Paper film 14 x 17 may also be used, as well as simple fluoroscopy. Standard 14 x 17 film may be used in small surveys sueh as general admissions to small hospitals, although both the eost and the seareity of this size make this procedure impractical at present. All are equally aceeptable as a sereening film. The ehief eonsideration is probably the number of films to be taken daily. The 35 mm. and 70 mm. are roll film with as many as 350 exposures to the roll. Obviously this is an advantage where large numbers of people are taken during a single day. The 4 x 5, on the other hand, may be taken on either single film or two exposures on a film 4 x 10 inehes. It has the advantage of almost immediate development and direet reading without the aid of a magnifying viewer, although it has the disadvantage of requiring the ehanging of film holders after each one or two exposures. We have used all three miniature size film and eannot see any great difference in their ability to deteet possible pathology. What difference exists is more of a personal experienee factor rather than an inherent inadequaey of the film to define the lesion.

The viewing equipment has been improved steadily and the eye strain whieh a few years ago was quite apparent, especially in reading 35 mm. film, has largely been obviated.

The desirability of using stereoscopy in miniature film work has been studied with the result that this method netted only 6 additional suspeets per 100,000 film read. It would therefore appear that a single film is entirely adequate for purposes of detection.

From the millions of small pietures taken by the Army, the Navy and in industries all over the country in the past 5 years, enough information has been gathered to determine beyond a doubt the extreme value of this procedure as another method by whieh more aecurate diagnosis may be made. Tubereulosis is not the only disease found in this new assault on man's ills. Other eonditions occurring in the chest are likewise uneovered.

The mass survey is not in itself a means of diagnosis. At best we should probably eall the mass survey a means of detecting apparently abnormal eonditions. The miniature film is a tool but does not replaee either the standard x-ray or the medical training and experienee of the practitioner. For all too many years, the tuberculosis eontrol program has suffered because the physician did not find tubereulosis, either before the infection had been spread to others or before

Presented before the Section on Public Health and Hygiene, 107th Annual Meeting, Illinois State Medical Society, May 12-14, 1947, Chicago.

the case had advanced to a stage where recovery was doubtful. Fully 75% or more of cases, year after year, are advanced before diagnosed. Some have blamed the physician, but the question remains, how can the physician diagnose the case until that individual comes to his attention.

The only reasonable answer is that we must look for the disease among the apparently healthy population. As an example, how many previously unknown cases of diabetes are found as a result of a routine urine examination. It is true that not every individual discovered to have sugar in a routine specimen of urine is a case of diabetes, and neither is every suspicious shadow on the miniature film a case of tuberculosis. The routine chest film reveals pathology in from 1 to 5% of all cases. Perhaps one-half of these may be considered as being of tuberculous origin and representing active or apparently healed disease. The other half, as mentioned earlier, are indicative of non-tuberculous pathology. Bronchiectasis, pneumonia, effusion, cardiac abnormalities, tumors, fractured ribs, diaphragmatic hernia, spontaneous pneumothorax, etc. may all be detected through the use of the small film. The mass survey opens up an entirely new field to each and every physician in active practice.

The most extensive survey in Illinois, exclusive of Chicago, is carried on by the Division of Tuberculosis Control of the Illinois Department of Public Health.

We began mobile x-ray survey work in 1943 following an introduction of this method of case finding in Illinois by the United States Public Health Service in 1942. However, for practical purposes, our experience dates back to January 10, 1946. In the sixteen months since then, more than 170,000 x-rays have been taken. The request for this service which is available anywhere in Illinois, generally originates from the local tuberculosis association, a civic club, the Health Department, the Farm Bureau or other health minded group.

The request for the use of a mobile x-ray unit of the Department of Public Health should be made through the full time city, county or district health officer.

The endorsement of the plan by the County Medical Society must be secured.

Upon receiving a request the health officer will meet jointly with the sponsoring organization and other intercsted groups such as management, labor, Farm Bureaus, the press, Parent and Teachers Associations, civic clubs, and the tuberculosis association, the sanatorium board and the local medical society to insure complete understanding of the reponsibilities involved.

An assurance of at least 4,000 or 20% of the adult population in a county should be had before forwarding the request to the Division of Tuberculosis Control. A minimum of 20% of the adult population seems necessary if a significant amount of the unknown tuberculosis is to be found. It appears that a county wide program is desirable. School surveys are not productive and industrial surveys do not reach the home maker. Units usually survey from 200 to 600 persons daily, depending upon the organization, weather, season and the principal industry in the county.

Provisions for rechecks of designated persons at needed intervals and hospitalization if indicated should be made locally.

The eligible group for x-ray includes any reactor to the tuberculin test among high school students and the entire adult population.

A publicity campaign is essential to the success of a survey. Publicity materials such as posters and pamphlets are available from the Department of Public Health, or the Illinois Tuberculosis Association. It is suggested that additional materials be developed locally to be used in the health education program preceding the x-raying. All publicity should be approved by a committee representing the cooperating agencies.

The film may be read either locally by the roentgenologist or the superintendent of the Sanatorium, if an institution is located in the county, or in the central office of the Division of Tuberculosis Control. Negative reports are sent to the individual direct. A letter is sent to the individual having an abnormal finding, suggesting that he consult his family physician. The family physician gets a copy of this letter and a notation as to the nature of the suspected pathology. The film is available to the physician upon request. Perhaps many of you (in the audience) have received a letter containing the information that one of your patients who visited a mass survey unit was thought to have possible tuberculosis or some other form of chest pathology. This letter was not a "mail-order" diagnosis. It was an impression that something

was wrong and it gave the physician an opportunity to investigate further, establish a diagnosis, and practice a preventive type of medicine. The individual who is asked to go to his physician is thankful that the small film detected a possible abnormality early and is anxious to have his physician determine its nature and prevent serious trouble later.

Inasmuch as the miniature film is a detection process, no suspect is counted as a reported case. The suspect must be studied carefully by history, physical examination, tuberculin test, standard x-ray, sputum study and possibly with the assistance of a chest specialist. It is for this purpose that the individual is referred to his family physician.

The other phases of the tuberculosis control program, namely: care, treatment, rehabilitation and protection of the family against economic stress, are phases which must not be neglected. They are necessary and should be planned even before the mass survey is undertaken. This is true regardless of whether the survey is of hospital admissions, a county or other group. These are community problems and affect each of us directly.

Results of the mass survey work during the calendar year 1946 show 107,005 films taken and 1726 suspicious cases of tuberculosis found. This is an average of 16.13 per 1000 film.

In the age group under 20, suspicious cases numbered 4.90 per 1,000.

In those from 20 to 40, 12.01 per 1,000.

In those from 40 to 60, 29.80 per 1,000 and

In those 60 and over 52.64 per 1,000.

It is well known that prior to the routine x-ray era from 70 to 90% of all cases diagnosed were beyond the minimal state. Our sanatoria admissions each year reveal 70 to 90% moderately or far advanced. This is not a reflection upon the ability of the physician to reach a diagnosis earlier, but, as mentioned previously, indicates that early tuberculosis is asymptomatic and that patients do not seek the physician until symptoms are present. Some cases could be found earlier if x-rays were routinely done on those with vague symptoms but by and large the answer lies in suspecting every one of possible tuberculosis.

Let us see what the surveys reveal in the character of lesions found. The various men reading film are asked to divide all suspicious findings into one of five (5) classifications: minimal, moderately advanced, far advanced, suspicious and "other tuberculosis". Most of those classified as suspicious are minimal in extent, and might well be grouped with the minimal cases. All of those classified as "other tuberculosis" are probably far advanced cases inasmuch as they represent those with thoracoplasties, pneumothorax and other old cases.

There were 685 classified as minimal, 259 moderately advanced and 76 far advanced. There were 681 suspicious and 25 with "other tuberculosis". If we consolidate the groups as suggested above we find 1366 minimal, 259 moderately advanced and 101 far advanced. This is 79.15% minimal, 15.00% moderately advanced and 5.85% far advanced. Thus, we reverse the percentages of minimal and advanced cases. By usual methods and under present day conditions 80% or more are advanced cases when diagnosed, while in survey work approximately 80% may be expected to be in the minimal stage. This means a tremendous saving in life, in family income and in the cost of the care of the sick and their families.

The mass survey principle is here to stay as long as tuberculosis is a medical problem. The mobile unit may be replaced in certain areas by photofluorographic equipment in industry and hospitals, but large segments of the population will be flourographed by mobile equipment to the mutual benefit of the individual and his family physician. The size of film is of little moment; the important point to remember is that the survey film detects but is not diagnostic.

The physician plays an all important part in the mass survey program. He gets the results of this detection process and the ultimate diagnosis of tuberculosis or of other pathology is up to him. A high index of suspicion of tuberculosis on the part of the medical profession is necessary.

A study of results of tuberculosis control programs in the past indicate that much time and energy probably have been devoted to the wrong population groups. Tuberculosis is not a disease found commonly in children and less frequently as age increases. The morbidity and mortality statistics both point to an opposite condition. Age specific death rates increase in the older age groups. The mass survey also indicates that the prevalence of tuberculosis increases with age.

This is the reason we ask that surveys be confined to those above 15 years of age and hope that the number of children will be kept at an absolute minimum. The apparent distribution of tuberculosis morbidity leads us to believe that the survey process should not be conducted in grade schools, but should be concentrated among industrial and other general adult population groups. We can protect children from tuberculosis by detecting tuberculosis among the parents who are the source cases. An adult population free of tuberculosis will result in a young generation free of infection. Tuberculosis is an infectious disease, spread almost entirely by adults. If all tuberculous adults could be found, isolated, treated and the disease arrested, the next generation would have practically no source of infection, and tuberculosis would become a relatively infrequent disease.

Roentgen Ray Aspects of Malignancies of the Small Intestines

Edwin L. Rypins, M.D.*
Bloomington

Malignancies of the small intestines are not common. Railford[4], in a review of 986 tumors of the gastrointestinal tract, found 776 to be malignant and, of this latter group, 38 were in the small intestines. Feldman[1] found the necropsy incidents to be about .05 per cent. In this group, 25 per cent were in the duodenum, 40 per cent in the jejunum, and 35 per cent in the ileum. Small intestine neoplasms tend to occur in middle life, the average age (Mayo)[5] being 52.6 years. They are 2½ times more common in men. Metastases occur early, probably due to abundant blood and lymph supply. Metastases occur in order of frequency to lymph nodes of the mesentery, peritoneum, liver, lungs, long bones, and dura mater (Leopard)[4]. Carcinoma of the small intestines may be divided into 4 main types, the first is the most common, (1) adenomatous, (2) medullary, (3) scirrhous, and (4) colloid. They may occur in 3 forms, namely, (1) polyp, which is undergoing malignant degeneration; (2) annular constricting lesion; and (3) carcinoid, which is the most common in the appendix (Leopard)[4].

Presented at the Illinois State Medical Society Meeting in Chicago, Illinois, on May 10, 1948.

***Deceased 7/4/48.**

Symptoms may be vague abdominal distress. Pain varies from vague discomfort to severe colic located in the region of the umbilicus. Pain in the epigastrium is a late symptom and may be evidence of metastases to retroperitoneal lymph glands. A palpable mass is a late finding and is usually movable. Persistent blood in the stools after stomach and large bowel lesions have been excluded is an important finding.

Prognosis is poor. Five year cures of 12.3 per cent (Mayo)[5] and operating mortality is about 47 per cent (Connolly and Tempke)[1].

Lesions of the large bowel should always be excluded before barium is given by mouth. Occasionally in annular lesion of the large bowel, when barium is given by mouth, will become an acute obstruction. Four ounces of plain barium sulphate with tap water is used. The stomach examination can be done at this time. The barium meal is followed through the entire small intestines and films are taken immediately after ingestion of the barium within 15 minutes and then within a half-hour. This will usually outline the jejunum fairly well. Films are then taken at 1 hour intervals until the meal has reached the cecum. The examination is somewhat time consuming since any

point where the meal seems to be delayed is examined under fluoroscope to find out if the area is movable and pliable. Needless to say, the patient has received no breakfast and gets nothing by mouth, except plain water, until the examination is completed. This may take 6 or 7 hours.

As a rule, malignancies of the small intestines produce a short constriction, while an inflammatory constriction is somewhat longer in length. Partial obstruction, particularly in the jejunum, is a very important finding. Filling defects of any type are also important. It is sometimes difficult to differentiate between partial obstruction due to malignancy of the ileum and due to adhesions, assuming that the patient has had previous laparotomy.

SUMMARY

(1) Roentgen ray aspects of malignancies of the small intestines are those of partial obstruction or filling defects.

(2) Blood in the stools after lesions of the large bowel and stomach have been excluded should cause one to have a proper examination of the small intestines by roentgen ray.

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DIAGNOSE LUNG CANCER BY EXAMINATION OF CELLS

Microscopic examination of sputum for cancer cells is a valuable aid to physicians in diagnosing cancer of the lung and pulmonary tuberculosis, according to three St. Louis physicians.

Writing in the November 13 issue of The Journal of the American Medical Association, the physicians — Martin Bergmann, Burton A. Shatz, and I. Jerome Flance, of the laboratory of the Jewish Hospital — point out that differentiating between cancer and tuberculosis of the upper part of the lung has been extremely difficult.

The only methods known for procuring tissue from the upper lobes for study under the microscope have undesirable aspects, and the areas are hard to visualize by means of x-rays, the physicians say. Tubercle bacilli are frequently not seen in the sputum in cases of early pulmonary tuberculosis.

Microscopic examination of sputum for cancerous cells gives a positive diagnosis in from 60 to 88 per cent of lung cancers and is an especially desirable technique for discovering lesions of the upper lobes of the lungs, they report.

"In the past several months we have examined the sputum of 158 patients. Three cases were of special interest in that a diagnosis of cancer was made by sputum examination at a time when the clinical diagnosis was tuberculosis or wavered between tuberculosis and cancer," the physicians say.

CASE REPORTS



Toothpick in Ascending Colon

C. W. Olsen, M.D., G. E. Johnson, M.D., F.A.C.S., and George Bilek, M.D.
Chicago

The finding of a foreign body in the intestine is not uncommon. It is rare, however, to encounter an ordinary toothpick. Snodgrass[1], in a review of the literature in 1946 collected 20 cases in which the foreign body was a toothpick and added one case of his own. In 13 of the cases the preoperative diagnosis was acute appendicitis, in two, abscess of the abdominal wall, in one, peritonitis, and in four cases the diagnosis was not determined before operation. In his own case the patient had been operated elsewhere under a diagnosis of acute appendicitis and the appendix removed. An incisional hernia developed and the patient complained of a sharp penetrating pain and a sensation of tearing of the scar. At operation for the repair of the hernia an object was noted in the bowel which "tented" it up and almost protruded through it. On opening the intestine the object was found to be a toothpick. On subsequent inquiry the patient said that he was accustomed to eating club sandwiches held together by toothpicks and that it was possible he had swallowed the toothpick without detecting it since the roof of his mouth was protected by an artificial denture.

The case herein reported is that of a white man, aged 56, who presented himself for examination because of severe abdominal pain and slight nausea which had been present for twenty-four hours. On examination there was exquisite tenderness just lateral to the umbilicus on the right side. Temperature was 100.6° and pulse 90. The leucocyte count was 13,650. A diagnosis of acute appendicitis was made and operation advised.

Under spinal anesthesia an upper right rectus, muscle-splitting incision was made and the abdomen opened. The appendix was examined and found to be normal. Further examination

showed a toothpick protruding from the proximal portion of the ascending colon. An opening was made in the ascending colon and the toothpick removed. Two rows of purse-string sutures and one row of interrupted sutures were used to close the opening in the intestine. The long appendix epiploica was anchored over the opening. The abdomen was closed in layers after inserting a Penrose drain into the region of ascending colon and sprinkling five grams of sulfathiazole into the abdominal cavity.

The specimen consisted of an elongated small piece of wood resembling a toothpick, 55mm. long and 1 to 2 mm. in diameter. It was intact throughout.

The patient was febrile until the fourth day. The drain was removed on the fifth day and the sutures on the ninth day. The patient was discharged on the tenth post-operative day.

COMMENT

According to Snodgrass, the presence of artificial dentures with consequent loss of sensory stimuli in the roof of the mouth and the gums, makes it easier to ingest unknowingly a foreign body in a morsel of food, and secondly, that cocktails, canapés and club sandwiches are conducive to the careless handling of toothpicks. That more trouble does not result is due to the mechanism in the intestinal tract which makes it possible to manage foreign bodies in great quantity without serious damage.

In our case the patient definitely remembered having eaten a club sandwich two weeks before; vague pains in the abdomen developed about two days later, gradually becoming more severe and two days before admission to the hospital settled in the region of the cecum.

6558 S. Halsted Street
1000 W. 59th Street

REFERENCES

1. Snodgrass, Thomas J.: Arch. Surg. October, 1947, pp. 441-456.



COUNCIL MEETING MINUTES



The regular meeting of the Council was held at the Palmer House, Chicago, on Sunday, November 7, with the following present: Hedge, Hopkins, Stevenson, Blair, Peairs, Norbury, Hulick, English, Lane, Otrich, Hamilton, Coleman, Saunders, Neece, Berghoff, Camp, Hughes, O'Neill, Harker, Stone, Hawkinson, Vaughn, Hutton, Pond, Oldfield, Hoeltgen, Cross, E. H. Blair, Chas. E. Pope, Leary, Neal, Esther Fraser, and Frances C. Zimmer. Minutes of last meeting were approved.

Secretary gave his report, opening his statements with a summary of the situation faced by the profession following the recent election. Referred to Interim Session of A.M.A. to be held in St. Louis. Illinois with nine delegates will have a new delegate seated in place of Hamilton who is a member of Board of Trustees. Bernard Klein, as Hamilton's alternate, has been certified as a member of the delegation. With increase in membership, this society now has enough members for an additional delegate.

The secret committee to select the Illinois outstanding general practitioner met in Chicago on October 17, to review all candidates as submitted by component societies.

Lee Turner Hoyt, M.D., Roseville, Illinois was selected as the winner, and his name and supporting factual data will be submitted to the Board of Trustees of the A.M.A. before November 15, as the Illinois candidate for the national award. The printing contract with the Wayside Press expires December 1, and the committee believes it should be renewed. The Journal Committee chairman, Dr. Hedge, will report later and make the recommendations of the committee. The Council should select the date and tell of the type of conference they desire to have scheduled for the annual conference of component and branch society officers. It was recommended that this be held in Springfield, and it seems desirable to have it during December, rather than after the first of the year. Chairman Hedge called attention to several things in secretary's report which he believed should be acted upon immediately.

MOTION; Hamilton-Harker, that secretary secure suitable emblem and scroll to be presented at next annual meeting to outstanding general practitioner. Motion carried.

MOTION; Hamilton-English; that officers of the Society arrange for an early conference of county and branch society officers to be held in Springfield; they to arrange the program, and secretary's office send out programs, etc., and make local arrangements. Motion carried.

MOTION; Hamilton-Hopkins; that secretary's report be received and made a matter of record. Motion carried.

HOPKINS reported as president, telling of recent trip to Honolulu, where he appeared on program of a big surgical society. Told of attending the conference of the secret committee to select the outstanding general practitioner. He had no idea who would be present until he entered the meeting room, and he was impressed with the business manner in which this meeting was held, and by which the final selection was made. Only the six members of the committee, from various parts of the state participated in these deliberations.

STEVENSON reported as president-elect referred to recent trends, and stressed the necessity of a united front to oppose all inroads on medicine as a private enterprise. Gave several suggestions as to what he thought should be done by the medical profession at the earliest possible moment.

HAMILTON referred to efforts being made to care for transients and recommendations to county societies to arrange lists of physicians willing to make night calls, as well as for some to be prepared to make emergency calls or give emergency attention on the regular half day off.

LANE reported on recent post graduate conference at Harrisburg, telling of the excellent program, good attendance, and unusually fine interest manifested throughout the day. Also reported on recent annual meeting of the Southern Illinois Medical Association and some resolutions which were adopted.

PEAIRS told of an essay contest under way in McLean County, on "Why the present method of providing medical care is better than any other proposed plan". $150.00 in prizes to be awarded to winning high school students, and there is much interest in that community.

The proposed Blue Cross-Blue Shield merger, and possible formation of a new insurance company to operate in all states was discussed.

MOTION; Hawkinson-Stevenson; that the Council go on record as opposed to the proposed amalgamation of Blue Cross and Blue Shield, and the formation of a national insurance company. That a copy of this resolution be sent to each delegate from this Society to the A.M.A., to the Board of Directors of Blue Cross, and to the Council on Medical Service of the A.M.A. Motion carried.

HUTTON reported as chairman of the committee on medical service and public relations, referring to a breakfast meeting on this date, of his committee. Committee unanimous in the opinion that arrangements should be made immediately in every county whereby a skeleton force will be available for emergency services on physician's half day off; also for night calls, and care of transients. This should be so reported to all component societies as early as possible, and placed in action everywhere. Hutton reported as chairman of the Editorial Board, telling of awards for best papers published during the past year, in the two classes. One awarded to Bert I. Beverly, posthumously, and the other to Kenneth L. Roper. Hutton also reported on progress of the committee on medical history, telling what is being done, and what has been proposed by his committee for the immediate future. Many historical records have been sent to the John Crerar Library, where assurance has been given that they will be well cared for, and title for same, remain in this society.

NEAL made supplementary remarks as executive secretary of the Committee on Medical Service and Public Relations, and James C. Leary as Public Relations Consultant. MOTION; Blair-Saunders; that the report be accepted and placed on file. Motion carried.

BLAIR reported as chairman of the Educational Committee, telling of the many activities of the committee from the Society's Chicago office. Told of recent meeting of this ocmmittee, and various actions which were taken. Gave a resume of the thousands of pieces of literature going each month from the office.

BERGHOFF reported as chairman of the Scientific Service Committee, and the Committee on Post Graduate Education. Many societies have been serviced in recent months, but he urged members to ask their county societies to use these services to a larger extent, and better advantage. Reported briefly on post graduate conferences at Harrisburg and Monmouth, and those scheduled for Rockford and Pekin.

HOPKINS reported as chairman of the Committee on Prepayment Care, telling of activities under way. One insurance company has been dropped, and the Aetna and Metropolitan Casualty Company have been approved for participation under the Illinois plan. Told of a meeting scheduled to be held in St. Louis by state society committees interested in this type of voluntary prepayment care plans, to be held during interim session of the A.M.A.

The following actions were taken:

1. The Council approved the participation of the committee on voluntary prepayment medical care in the proposed group work, and that the committee proceed with the proposed plans, as outlined by Hopkins.

2. That 10,000 additional copies of the brochure "Doctors and Horses" be published for general distribution, the supply having been exhausted.

3. The fee schedule for services rendered under the Illinois plan for home town care of veterans, be mimeographed and made available for those desiring copies. There were some changes made from the previous printed schedule, and as these are to be used until next June, it was not deemed advisable to publish them at this time.

E. H. BLAIR reported as chairman of the Committee on Military Affairs and Emergency Medical Service, telling of a recent meeting of his committee, and the several recommendations to the Council. He stated that they have been in close touch with the A.M.A. Committee, and desire to cooperate fully in this important work. Philadelphia has formulated what is believed to be the first and most successful disaster relief plan.

MOTION; Neece-English; that the chairman be sent to Philadelphia to study their plan and see it in operation; also that the report of Blair be approved, with the recommendations of his committee. Motion approved.

COLEMAN gave his report as chairman of the Medical Advisory Committee to the Illinois Public Aid Commission. Told of recent problems, and referred to the one which has existed in Cook County since the plan was placed into effect.

HEDGE reported as chairman of the Journal Committee, telling the Council that his committee recommends that the contract with the Wayside Press be renewed, as the printing has been highly satisfactory, and the prices acceptable. By proper action this recommendation was approved.

Hedge also recommended that the contract with Mr. L. E. Malley, as Business Manager for the Illinois Medical Journal, be renewed for another year. Motion carried.

ENGLISH reported as chairman of the Committee on Rural Medical Service, in which he proposed a Conference on Rural Medical Service to be held preferably in Springfield, to which county chairmen of the Illinois Agricultural Association, and 4-H Club leaders in every county should be invited. This meeting he believes should be held soon after the first of the year.

By proper action, this recommendation was approved.

CROSS told of the desire of his department to assist in this conference, and anything that could be done in his office, would be done, including the use of personnel. He stated that ground had been broken for the new state tuberculosis hospital at Mt. Vernon, and during 1949, they hope to have the Cook County units likewise under way.

HOELTGEN reported as chairman of the Committee on Arrangements for the 1949 annual meeting to be held in Chicago May 16-18. He attended the recent meeting of the Committee on Scientific Work at which tentative plans were made for an outstanding scientific program. His several committees will be announced in the near future.

MOTION; Harker-Neece; that the minutes of the recent meeting of this committee and their recommendations for scientific programs, be approved. Motion carried.

The following actions were likewise taken:

1. Contract with John W. Neal, as General Counsel be renewed on December 1.
2. Arrangements approved for expenses of delegates to A.M.A. interim session in St. Louis.
3. That $25.00 be contributed to the Illinois State Nutrition Committee for their fine work.
4. Exhibits in the Scientific Exhibit for the annual meeting, from out of state exhibitors be approved, if space is available.
5. Secretary instructed to write each component society urging that more scientific exhibits be prepared by physicians in their area.

The following were elected to Emeritus Membership:

Frederick Tice, Chicago
Oscar Cleff, Chicago
H. S. Zimmerman, Cameron

Past Service Membership:

Horace R. Lyons, N. C., recommended by C. M. S.
Joseph H. Blomer, Quincy
M. J. Kaye, Waukegan
W. V. Gooder, Marengo

The bills, as audited by the finance committee, were approved by proper action. During the luncheon period, Warren H. Cole gave an interesting talk on medical care in England today, he having recently returned following a four month intensive study of medical care, hospitalization, and medical education. This talk was highly instructive, and many questions were asked by a number following the presentation.

Adjournment at 2:30 P.M.

PSYCHIATRIC UNITS IN GENERAL HOSPITALS

The presence of a psychiatric unit in a general hospital will make adequate early treatment available to great numbers of patients who would otherwise not receive it.

The educational and mental hygiene opportunities in a community possessing a psychiatric division in a general hospital are obvious, and over a period of years may well prove effective in determining a more healthy mode of life for many individuals, who will never be seen as patients.—John D. O'Brien, M. D., in Ohio St. Med. J.

To advocate the indiscriminate use of streptomycin, especially in moderately advanced or advanced cases of pulmonary tuberculosis, not only is premature but also carries with it certain dangers and drawbacks. Among the principal dangers in the use of this drug is its toxicity, which may seriously affect hearing, sight and kidney function and cause skin eruptions. At present, it can only be said that we have seen little in the treatment of well established pulmonary tuberculosis by streptomycin that gives cause for any great optimism regarding its curative value. Comm. on Tuberc., N.H. Med. Soc., New England J. Med., Oct 23, 1947.

NEWS OF THE STATE



BUREAU

Society News.—Dr. John T. Boswell, Kewanee, was guest speaker at a recent meeting of the Bureau County Medical Society at the Perry Memorial Hospital in Princeton.

CARROLL

Society Honors Dr. Schreiter.—The Carroll County Medical Society, October 21, selected Dr. J. B. Schreiter, Savanna, as its outstanding general practitioner. The Society adopted a resolution eulogizing the physician. Dr. Schreiter was the first commander of the Savanna Post No. 148, now known as the Van Bibber-Hansen Post No. 148, a veteran officer of World War I, and has been reelected many times to the office of coroner of the county.

CHAMPAIGN

Society Urges Increased Tax for Public Health.—The Champaign County Medical Society, at a meeting October 14, unanimously adopted the following resolution: "Resolved, that the Champaign County Society go on record as heartily endorsing the proposed increased tax by the Sanitary Tax Law to be voted on at the coming election, since this Society favors every means of providing the best possible public health measures for this community."

James Mason Chosen Outstanding Practitioner for County.—Dr. James S. Mason, Urbana, was named by the Champaign County Medical Society, October 14, as its outstanding general practitioner for 1948. Dr. Mason has practiced in the county for more than fifty years, is a member of the Fifty Year Club of the Illinois State Medical Society and is a former president of the county medical society.

Society News.—Dr. Herman N. Levy, clinical associate in medicine, University of Illinois College of Medicine, addressed the Champaign County Medical Society recently on "Common Unrecognized Allergic Conditions." Dr. R. J. Brennan was program chairman.

CLARK

Public Meeting Honors Physician.—More than 600 persons gathered at the high school in Casey, October 14, to honor Dr. R. B. Boyd with a farewell program for his forty years of service to the community. Dr. and Mrs. Boyd left October 25 to make their home in San Angelo, Texas, for reasons of health. They were presented with a modern electric clock on which was inscribed "Presented to Dr. and Mrs. R. B. Boyd from the Casey Community, in recognition of forty years service.

Society Favors Health Department.—The Clark County Medical Society recently voted in favor of the establishment of a full time health department in Clark County.

COOK

The Chicago Diabetes Association.—On October 29, 1948 a group of Chicago physicians, nurses, dietitians and laymen met to organize a Chicago Diabetes Association. The group will be incorporated under the laws of the State of Illinois and will eventually apply for affiliate status to the American Diabetes Association upon whose invitation the Chicago Association was formed. Officers are: President, Dr. Arthur R. Colwell; Vice President, Dr. Samuel Soskin; Secretary, Dr. Henry T. Ricketts; Treasurer, Mr. Paul Dice.

The purpose of the Association is "to promote the acquisition and dissemination of useful and accurate information regarding the disease diabetes mellitus and to undertake such activities as will improve the welfare of the diabetic population." The Association will take a leading part, in collaboration with a committee of the Chicago Medical Society, in the approaching Diabetes Detection Drive.

After organizing procedures are completed the membership will be expanded and classified so as to include other physicians, nurses and dietitians as well as social workers and technicians. An affiliated organization for the benefit of all others interested in diabetes will be formed later.

Dr. Purves Chosen Outstanding Physician.—Dr. A. M. Purves, Des Plaines, was nominated by the Irving Park Branch of the Chicago Medical Society, as the outstanding practitioner in the Northwest district. Dr. Purves has been practicing in Des Plaines for forty-five years. He graduated at Bennett College of Eclectic Medicine and Surgery in 1901.

Personal.—Dr. S. B. Kositchek retired recently from the medical staff of Commonwealth Edison Company, after thirty-five years service. — Dr. James J. Callahan attended the International Orthopedics Congress in Amsterdam, Holland, in September, as one of three delegates from the United States. — Dr. J. P. Greenhill, Chicago, recently returned from South America where he gave twenty-one talks on Obstetrics and Gynecology in Spanish in five countries. — Dr. Edmund Jacobson addressed the New York Academy of Science Section in Psychology, October 18, on "Theory of Essential Hypertension in Man" — Dr. Raymond W. McNealy, Chicago, discussed "Carcinoma of the Large Bowel and Rectum" before the South Dakota Division of the American Cancer Society in Sioux Falls, South Dakota, October 13, and addressed the Sedgwick County Medical Society, November 2, in Wichita, Kansas, on "Pre-Operative Care of Large Bowel Cases." — Dr. A. C. Ivy, vice president of the University of Illinois in charge of the Chicago Professional Colleges, was given an honorary degree by Boston University recently. Dr. Ivy received the degree at a ceremony marking the formal observance of the centennial anniversary of the Boston University School of Medicine. As his part in the program, Dr. Ivy discussed "Enterogastrone and Peptic Ulcer." — Viola Mae Young, parasitoligist at Cook County Hospital, was elected Fellow of the Royal Society of Tropical Medicine and Hygiene in London, June 18. Her election was sponsored by Sir Philip Manson-Bahr. — Dr. Raymond W. McNealy discussed "Tumors of the Neck" at the thirteenth Annual Assembly of the United States Chapter of the International College of Surgeons in St. Louis, November 16.

Physicians Participate in Medical Missions.—Three members of the faculty of the University of Illinois College of Medicine recently participated in medical missions outside of the United States as expert consultants to the Surgeon General. Dr. H. Worley Kendell, appointed for a military mission to Tokyo, Japan, is a member of a team of four physicians who visited military hospitals in Hawaii, the Philippines, Guam and Japan. Dr. G. A. Bennett left Chicago on November 12 to visit military hospitals in the Canal Zone, to instruct military personnel anl observe procedures used in hospitals in that area. Dr. Percival Bailey returned in October following a six-week medical mission to the Pacific theatre. Dr. Bailey and four other physicians were members to the mission which visited Guam, the Philippines and Japan. On the misson, Dr. Bailey gave several lectures and conducted clinics for military personnel. The purpose of the missions is to further promote and improve the quality of medical care and instructions in Army medical installations. Consultants participating in the missions assisted and advised the theatre surgeons and hospital staffs in the treatment of patients. The participants conduct clinics, make ward rounds, give lectures, and perform other teaching functions that may be required. Following the completion of the missions, participants are asked to forward reports to the United States Surgeons General.

English Plastic Surgeon Visitor.—Sir Archibald McIndoe, chief of plastic surgery for the R.A.F. during the war, visited medical institutions in Chicago in November. He presented a lecture on "Total Reconstruction of the Face Following Burns", November 10, at the University of Illinois College of Medicine. His presentation was sponsored by the Association of Interns and Medical Students.

Sir Archibald now serves as senior plastic surgeon at St. Bartholomew's hospital in London, and as surgeon in charge of plastic surgery at the Queen Victoria hospital in East Grinstead. He is also chief consultant in plastic surgery for the R.A.F. at the present time.

Sir Archibald was formerly associated with Sir Harold Gillies, one of the fathers of plastic surgery.

Dr. Igloe Joins Medical Faculty.—Dr. Max C. Igloe, head of the Chicago Health Department's new District Health Center, has been appointed to the faculty of the University of Illinois College of Medicine.

Dean John B. Youmans announced that Dr. Igloe will serve as an associate professor in the department of preventive medicine and public health on 16 percent time.

Before joining the Chicago Health Department, Dr. Igloe served as chief of the outpatient section of the Veterans Administration branch of Chicago. He held the rank of Lieutenant Colonel during the war and was in charge of the 3rd Army Military Government Public Health Section from 1942 to 1946.

Branch Meetings.— The North Shore Branch of the Chicago Medical Society was addressed November 2 by Dr. Geza de Takats, associate professor of surgery and head of the vascular division, University of Illinois College of Medicine, on "Problems Encountered in the Treatment of Varicose Veins" and Dr. F. A. Gibbs, associate professor of psychiatry, University of Illinois College of Medicine, on "Psychomotor Epilepsy." The discussants were Dr. Walter Carroll, associate in surgery, Northwestern University Medical School, and Dr. Theodore Rasmussen, University of Chicago School of Medicine, respectively. Dr. Ford K. Hick, professor of medicine, University of Illinois College of Medicine, discussed "Physiology of Heat Regulation" on October 15 before the Northwest Branch of the Chicago Medical Society. "Carcinoma of the Rectum" was discussed by Dr. Peter Rosi, assistant professor of surgery, Northwestern University Medical School, before the Northwest Branch of the Chicago Medical Society, November 5. Dr. Andrew C. Ivy, vice president of the Chicago Professional Colleges, University of Illinois, and Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois College of Medicine, were the speakers before the North Suburban Branch of the Chicago Medical Society, October 11, on "Newer Concepts of Peptic Ulcer." The discussants were Drs. Frederick Christopher and Robert W. Keeton. Dr. Martha R. Folk, clinical assistant professor of ophthalmology, addressed the South Side Branch of the Chicago Medical Society, October 14, on "Ophthalmology in Relation to Pediatrics." Drs. E. B. Freilich, Phil Aries and L. S. Tichy addressed the Douglas Park Branch of the Chicago Medical Society, October 19 on "Acute Respiratory Infections." "Modern Advances in Anesthesiology" was discussed October 19 by Dr. W. Allen Conroy before the Southern Cook County Branch of the Chicago Medical Society.

Specialty Society Officers.—The officers recently chosen at a meeting of the Chicago Society of Allergy are Drs. Edward G. Tatge, president; Morris A. Kaplan, vice president; and Theron G. Randolph, secretary-treasurer.—At a recent meeting of the Illinois Psychiatric Society the following were elected to office: Doctors Benjamin Boshes, president; Thomas M. French, vice-president; William Weisdorf, secretary-treasurer; and Ralph C. Hamill and Roy R. Grinker, councilors.

Arthur Newitt Goes to Michigan.—Dr. Arthur W. Newitt, formerly head of the Chicago Municipal Tuberculosis Sanitarium, has accepted an appointment as tuberculosis control officer for the state of Michigan.

Francis Lederer Surveys Mexico Hearing Needs.— Dr. Francis L. Lederer, professor and head of the department of otolaryngology, University of Illinois College of Medicine, recently conducted a survey of hearing and speech needs in Mexico. The work was conducted at the invitation of the Undersecretary of Health and Welfare of Mexico. Dr. Lederer also participated in the first postgraduate course in otolaryngology offered by the University of Mexico Medical School.

University Lectures.—Dr. Jules H. Masserman, assistant professor of psychiatry, Northwestern University Medical School, gave an assembly hour lecture October 27 at the University of Illinois College of Medicine on "Behavior and Neurosis" under the auspices of the Phi Lambda Kappa Fraternity. — Dr. B. P. Babkin, professor of physiology, McGill University Faculty of Medicine, Montreal, Canada, lectured at the University October 29 on "The Origin of Conditioned Reflexes." — Dr. Warren H. Cole, professor of surgery, University of Illinois College of Medicine, recently gave an assembly hour lecture at the University on "Medicine and Surgery in England." — Dr. Herman C. Mason, formerly advisor to Corean National Institute of Health for Medicine, Chemistry and Veterinary Science and currently associate professor of bacteriology at the Stritch School of Medicine of Loyola, discussed "Public Health Adventures in the Orient" during an assembly hour, November 3, at the University of Illinois College of Medicine.

Paul Cannon Awarded Medal.—Dr. Paul R. Cannon, internationally-known pathologist of the University of Chicago, was awarded the William Wood Gerhard Gold Medal of the Pathological Society of Philadelphia for outstanding work in medical research, it was announced November 11. The second honor which has been recently awarded the "starred man of science," the gold medal is the highest tribute of the oldest pathological society in America. On October 13, Dr. Cannon was presented the Ward Burdick Award-Medal of the American Society of Clinical Pathologists, largest society of pathologists in the United States. A pathologist with extensive training in bacteriology, Dr. Cannon is particularly interested in the pathological aspects of immunity as the background to infectious diseases. He has demonstrated the fundamental importance of proteins in the establishment of antibody mechanisms and in the recovery of malnourished persons by adequate feeding procedure. He has also demonstrated the vital importance of protein nutrition in wound healing, in antibody formation, in resistance to experimental infections and in convalescence, appetite, and resistance to infection. His investigation was applied to nutrition probdems in the armed forces and to the postwar problems in rehabilitation programs. A consultant to the secretary of war from 1941 to 1945, Dr. Cannon was a consultant to the food and container institute of the quartermaster department of the U. S. Army and a member of the biochemical advisory panel of the office of naval research. He also served as chairman of the committee on protein foods and the committee on diagnosis and pathology of nutritional deficiencies of the Food and Nutrition Board of the National

Research Council. He is now serving as a consultant to the Argonne National Laboratory. Elected to the National Academy of Sciences in 1944, Dr. Cannon has served as president of the American Association of Immunologists, the American Association of Pathologists and Bacteriologists, and the American Society of Experimental Pathologists. A graduate of the University of Chicago, Dr. Cannon received his doctor of philosophy degree in 1921 and his doctor of medicine degree in 1926 from Rush Medical College — then a part of the University of Chicago.

University News.—Dr. Leroy W. Earley has been promoted to the rank of assistant professor of pychiatry at the University of Illinois College of Medicine, Dean John B. Youmans has announced.

Dr. Earley formerly held the rank of instructor in psychiatry on one-half time, and psychiatric consultant in Health Service on one-half time. Dr. Joel Handler has been appointed psychiatric consultant in Health Service to replace Dr. Earley.

Dr. Early joined the faculty of the University of Illinois two years ago. He received the bachelor of arts and bachelor of science degrees from the University of Oklahoma, and the doctor of medicine degree from the University of Chicago. His Army assignments during the war included chief of neuropsychiatry at the 226th General Hospital.

Survey Indicate Expansion of Geriatrics Division.—A questionnaire sent to doctors and hospitals which indicated that at least 15,000 new cases of cancer appeared in Chicago last year, emphasizes the need for expansion of the division of geriatrics in the Chicago Health Department, a statement by the Committee on the Chicago-Cook County Health Survey said today.

The committee, which is sponsored by the Council of Social Agencies of Chicago, has as its objective the development of the health protective machinery of city and county along the lines laid down by the experts who made the survey last year.

One of the major recommendations of the survey was the establishment of the division of geriatrics, which means the treatment of the diseases of old age, in the Health Department. The validity of the recommendation was recognized by the City Council last year when it approved the 1948 budget increase involved.

Now the need for development of the embryo division arises, the Committe pointed out. As constituted, it has two sections, one devoted to heart disease, the other to cancer.

The questionnaire was part of the effort to outline the problems of the cancer section. It was answered by 90 per cent of the physicians and 96 per cent of the hospitals queried. More than 7,000 persons died of cancer in Chicago last year.

The major difficulties of the new division have been financial, but plans are being made to obtain outside funds for expanding and operating the department. State or federal funds and the American Cancer Society constitute the major sources of such assistance.

The next project will be a survey of the problem of cancer in industry, which will provide a basis for an attack on cancer due to cancer-causing substances encountered by workers. Such cancers are often the most readily preventable forms of the disease.

Little public money is spent on cancer in Chicago, the committee pointed out, despite this high death rate, though a total of approximately $1,000,000 is spent on syphilis, which produces some 2,500 cases a year.

War Efforts Recognized.—Dr. A. C. Ivy and Dr. John B. Youmans of The University of Illinois Chicago Professional Colleges at a recent ceremony received recognition for their services during the war. Dr. Ivy, vice-president of the University of Illinois in charge of the Chicago Professional Colleges, received the President's Certificate of Merit. Dr. Youmans, dean of the College of Medicine, received the Army-Navy Certificate of Merit. The certificates were given in recognition for the wartime services of distinguished scientists and engineers of the Office of Scientific Research and Development. The certificates were awarded by Major General John P. Lucas, deputy commander of the Fifth Army, and Captain Phillip G. Stokes, commandant of the Naval ROTC at the University of Illinois.

Joint Medical Meetings.—Dr. A. McGehee Harvey, professor of medicine, Johns Hopkins University School of Medicine, Baltimore, gave an illustrated lecture at a joint meeting of the Institute of Medicine of Chicago and the Chicago Society of Internal Medicine at the Palmer House, October 22. His subject was "Some Physiological Experiments of Nature in the Field of Neuromuscular Function: Potassium Deficiency, Potassium Intoxication, Myasthenia Gravis." The Institute held a joint meeting with the Society of Medical History of Chicago, November 19, to hear Dr. Howard Dittrick discuss "Temple to Hospital in Care of the Sick." The speaker is associate professor of medical history at the Frank E. Bunts Educational Institute, Cleveland, Ohio. Dr. Dallas B. Phemister gave the presidential address, December 7, at the thirty-third annual meeting of the Fellows of the Institute in the Congress Hotel, Chicago.

Allergy Research at Northwestern.—A new allergy research laboratory has been established at Northwestern University through grants from the U. S. Public Health Service and several pharmaceutical manufacturers. A long range program into research on allergy will be under the direction of Dr. Samuel M. Feinberg, associate professor of medicine and chief of the division of allergy at the school. The laboratory research will be directed by Dr. Saul Malkiel, formerly of the Rockefeller Institute for Medical Research.

Appointments at Stritch.—Dr. Albert G. Denton was appointed clinical assistant in medicine and Dr. Fred R. Schwartz, to a similar post in dermatology at Stritch University School of Medicine of Loyola, it was announced recently.

Alfred Lewy Honored.—At the November 1 meeting of the Chicago Laryngological and Otological Society, Dr. Alfred Lewy was presented with the traditional cane of the Society which was started in circulation by the late Dr. Joseph C. Beck. It is held as the temporary property of the Senior living member of the Society. It contains in its handle models of several otolaryngological instruments. In accepting the presentation Dr. Lewy thanked the Society and stated that he felt that he had earned it by a wise choice of ancestors. He intended to hold on to it and not pass it on to any successor for a long time to come. The cane has now been in the possession of Dr. J. C. Beck, T. Melville Hardie and George Shambaugh Sr.

DU PAGE

Personal.—Dr. William L. McNamara has been appointed full time director of the pathology department of Memorial Hospital, Elmhurst. Dr. McNamara left Hines Hospital to accept this position.

EFFINGHAM

Fifty Years of Practice.—Dr. Henry Taphorn was presented with the certificate and emblem signifying membership in the Fifty Year Club of the Illinois State Medical Society, September 23, during a meeting of the Effingham County Medical Society. Dr. Taphorn graduated at Washington University School of Medicine, St. Louis; following his internship he practiced for a time in Alton and East St. Louis, moving to Effingham in 1903.

FORD

Dr. Colteaux Retires.—Dr. John A. Colteaux, Roberts, has announced his retirement from the active practice of medicne, concluding thirty-seven years of service. Dr. Colteaux graduated at the Chicago College of Medicine and Surgery, 1911. Following his graduation, he practiced for three months in Thawville before going to Roberts. Dr. Colteaux has turned over his practice to Dr. Clyde A. Rulison who has been associated with him as partner for the past year. Dr. Colteaux owned and operated the first hospital in Ford county, known as Roberts Hospital.

FULTON

Society Tours Harvester Plant.—Members of the Fulton County Medical Society were guests of the International Harvester Plant recently. Following a tour of the plant and a dinner, emblems and certificates signifying membership in the Fifty Year Club of the Illinois State Medical Society were presented to Drs. Maud Rogers and G. S. Betts by Dr. Charles P. Blair, Monmouth, Councilor for the District. Dr. Burton C. Kilbourne, Chicago, addressed the meeting on "Fractures of the Hands." Dr. Betts and Dr. C. H. Hamilton are now emeritus members of the Illinois State Medical Society, according to recent action of the state council.

KANE

Personal.—Dr. Perry Allerton was recently elected president of the medical staff of Sherman Hospital succeeding Dr. Gordon Abbott.

LA SALLE

Outstanding Practitioner Named.— Dr. J. S. Geen, Utica, was chosen by the La Salle County Medical Society as its outstanding general practitioner. Dr. Geen, who graduated at Baltimore Medical College in 1896 and has been practicing in Utica for more than fifty-two years. He is president of the board of directors of the La Salle County Highland Tuberculosis Sanatorium and recently observed his fiftieth wedding anniversary.

R. H. Woods Retires.— Dr. R. H. Woods has retired from active practice after thirty-five years of service. He has turned over his practice to Dr. Edward Gallardo. Dr. Woods is seventy-three years of age.

MACON

Society News.—The Macon County Medical Society was recently addressed by Dr. Howard A. Lindberg on "The Problem of High Blood Pressure and the Solutions Evolving from Recent Research." — A joint meeting of the Illinois Trudeau Society and the Macon County Medical Society was held October 29 at the Macon County Tuberculosis Sanatorium in Decatur. Dr. Kenneth Bulley, Aurora, president of the Illinois Trudeau Society, presided at the afternoon program which included the following speakers: Dr. E. T. McEnery, Chicago, "Diseases of the Chest in Infancy and Childhood"; Dr. Richard Maxwell, St. Louis, Mo., "Chest Diseases in the Aged" and Dr. D. F. Loewen, Decatur Tuberculosis as Found and Missed in Macon County. Dr. Fred Ferguson, Decatur, president of the Macon County Medical Society, presided at the evening session held at the Decatur Club. The principal speaker was Dr. Thomas A Burford, St. Louis, Mo., "Modern Methods of Diagnosis and Treatment of Surgical Diseases of the Chest."

MACOUPIN

Society News.—The Macoupin County Medical Society was addressed in Carlinville, September 28, by Dr. Leland J. Hanchett on "Treatment of Venereal Diseases" and Dr. Leonard M. Schuman on "Venereal Disease Control." Dr. Hanchett is medical officer of Midwestern Medical Center maintained in St. Louis by the U. S. Public Health Service in connection with the Naval Hospital for the treatment of veneral diseases. Dr. Schuman, formerly with the U. S. Public Health Service, is now with the Illinois Department of Public Health.

MADISON

Personal.—Dr. H. A. Mittleman, East Alton, was recently appointed physician for the East Alton-

Wood River High School, succeeding Dr. E. R. Quinn.

MARSHALL

Personal.—A celebration, October 10, marked the birthday of Dr. J. P. Johnson, Varna, as well as the completion of thirty years of practice in the community.

MC DONOUGH

New County Officers.—Dr. V. B. Adams, Macomb, was elected president of the McDonough County Medical Society, October 24, succeeding Dr. W. P. Standard. Other officers chosen were Doctors R. G. Trummel, Bushnell, first vice president; Bruce Borum, Blandinsville, second vice president; R. C. Benkendorf, Bushnell, reelected secretary-treasurer; R. F. Millet, Macomb, delegate to the Illinois State Medical Society; Dr. Adams, alternate; W. E. Carnahan, Macomb, necrologist; R. L. Franck, Bushnell, membership board; and J. Henry Hermetet, Macomb, board of censors. Dr. Hobard Wallace and Dr. John R. Vonachen, both of Peoria, were the speakers. The title of their talks were "Tubercular Meningitis" and "Infant Feeding and Other Pediatric Problems", respectively.

McHENRY

Secretary Reports on Recent Meetings.—The McHenry County Medical Society met at the Fiesta at Crystal Lake, September 16, for its first fall meeting. This meeting was entirely a business meeting. At the April meeting, Dr. David E. Markson, Chicago, gave an excellent talk on "Arthritis" covering all phases of the field as to types of arthritis and forms of treatment. He talked from slides and the subject was well organized and delivered in a very scholarly fashion. On May 20, at the regular meeting of the county medical society, Dr. Herbert Rattner, Chicago, gave an excellent talk from slides on "The Common Skin Diseases: Their Diagnosis and Treatment". Both speakers are very well recommended for other medical societies as their information was not only interesting but extremely practical. All those attending the meetings felt that the evenings were very profitably spent. Dr. J. H. Goodlad, Harvard, is secretary of the McHenry County Medical Society.

MERCER

Park Dedicated to Memory of Physician.—Special ceremonies were held September 19 to dedicate the Miles Memorial Park in Viola to the memory of the late Dr. Walter Miles. Mrs. Miles unveiled the pillars at the park's entrance. Dr. V. A. McClanahan, Aledo, and formerly of Viola, president of the county medical society, spoke for the society.

MONTGOMERY

Society Election.—Dr. Nelson K. Floreth, Litchfield, was chosen president of the Montgomery County Medical Society, October 6, succeeding Dr. Harry Yaeger. Other officers include Dr. J. Robert Rebillot, vice president and Dr. George Allen, secretary-treasurer.

PEORIA

Dr. Horwitz Honored.—Members of the staff of the State Department of Public Health gave a special luncheon at the Elks Club, Springfield, October 27, to honor Dr. Sandor Horwitz, Peoria, state health superintendent of district No. 7, on the eve of his retirement from state service. Dr. Horwitz has been identified with the State Department of Public Health since 1931.

Personal.—Dr. Horatio C. Wood recently announced the opening of his office at 515 Central National Bank Building, Peoria. He is limiting his practice to psychiatry. — Dr. Philip R. McGrath has been elected president of the St. Francis Hospital staff to succeed Dr. George Mason Parker. Other officers include Dr. Hugh E. Cooper, vice-president, Dr. Edward J. Giunta, who was reelected secretary-treasurer.

Symposium on Heart Disease.—A symposium on heart disease was sponsored by the Illinois Heart Association and the Peoria County Medical Society, October 26 in Peoria, with Dr. Harry Durkin, president, Illinois Heart Association, presiding. The speakers on the afternoon program included Dr. Stanley Gibson, Chicago, chief of staff, The Children's Memorial Hospital, "Rheumatic Fever"; Dr. Chauncey C. Maher, Chicago, associate professor of medicine, Northwestern University Medical School, "Hypertension" and Dr. Paul Dudley White, professor of medicine, Harvard Medical School, "Coronary Disease." At the evening session, at which Dr. F. G. Maurer, president, Peoria County Medical Society, presided, Dr. White spoke on "The National Heart Institute."

Society Commends Newspaper.—Dr. E. Owen, Secretary, Peoria Medical Society sent the following letter to the Peoria Journal-Transcript which appeared in its issue for October 11: The Council of the Peoria Medical Society at its last meeting, October 1, 1948, requested that I, as secretary of the Peoria Medical Society, write to you and advise you that the Peoria Medical Society approves of and is pleased with the stand which your newspaper has taken on the subject of nationalized, socialized, state or political medicine. This type of private enterprise is one American institution that should continue as it is. Should the government of the United States attempt to administer medical service it would indeed undermine the present high standard of medical care which the public is now receiving. We, of the Peoria Medical Society, feel that our newspapers have again taken an attitude which is in the best interest of the public which they and we serve."

ROCK ISLAND

Society News.—Dr. Percy E. Hopkins, Chicago, President of the Illinois State Medical Society, discussed "Congenital Hypertrophic Pyloric Stenosis" before the Rock Island County Medical Society in Rock Island, October 12.

John Souders Honored.—The Rock Island County Medical Society on October 12 chose Dr. John C. Souders as its outstanding general practitioner for the year 1948. Aged 76, Dr. Souders is still in active practice. Dr. Souders practiced for a year in Reynolds before coming to Rock Island in 1905. He formerly served as president of the County Medical Society and of the Iowa-Illinois Central District Medical Association.

SCHUYLER

Society News.—Dr. Everett P. Coleman, Canton, discussed "Legislative Problems in Relation to Public Health" before the Rushville Woman's Club, September 16.

WILLIAMSON

Society News.—Dr. Edmund A. Smolik, St. Louis, addressed the Six County Medical Society in Herrin, November 18 on "Brain Tumors and Their Diagnosis." The Williamson County Medical Society, of which Dr. M. M. May is secretary, was host. Other societies in the unit include Perry, Jackson, Randolph, Union, and Franklin county medical societies.

WINNEBAGO

Years of Practice Honored.—At a recent meeting of the Winnebago County Medical Society, Dr. Egbert W. Fell was presented with a certificate for having completed thirty-five years of practice in Illinois. Dr. Sanford Catlin, new member of the Fifty Year Club of the Illinois State Medical Society, was present at the meeting which was presided over by Dr. Alexander Braze, president of the county medical society.

GENERAL

Exhibit on Amino Acids Wins Award.—An exhibit entitled "Amino Acids in Clinical Medicine" by Doctors Karl A. Meyer, Donald D. Kozoll, William S. Hoffman, Frederick Steigmann and Hans Popper from the Hektoen Institute for Medical Research received first prize at the recent meeting of the Mississippi Valley Medical Society in Springfield.

Criteria for the Diagnosis of Diabetes Mellitus.—For the information of physicians cooperating in the Diabetes Detection Drive the following criteria have been adopted by the American Diabetes Association:

I. Laboratory findings which indicate diabetes with certainty. Any amount of glucose in the urine plus high blood sugar. Venous blood sugar-by Folin-Wu method, over 130 fasting, 200 after eating. By Somogyi method, over 100 fasting, 140 after eating (or other method indicating true glucose value.) Capillary blood sugar, over 140 fasting, 240 after eating. When the reports are close to these values or when there is a fever or acute complicating illness, repeated blood sugar tests should be secured, or a glucose tolerance test performed for verification. The glucose tolerance test should be done under normal conditions; the diet for three days in advance of the test should include at least 250 gm. of carbohydrate.

2. Laboratory findings which usually rule out diabetes. A venous blood sugar below 140 by the Folin-Wu method or below 100 by the Somogyi method, 30 to 90 minutes after a meal containing the usual amount of carbohydrate, providing the diet has not been restricted previously.

What the Individual Physician Can Do to Aid in The Diabetes Detection Drive

(a) Test your own urine today.

(b) Make tests for all the members of your family this week.

(c) Make a urinalysis for every new patient routinely.

(d) Repeat the urinalysis for any old patient who has had an acute illness.

(e) Make a urinalysis every three to six months for obese patients and relatives of diabetics under observation.

(f) Urge every diabetic patient to see that his relatives have urine tests before Diabetes Week.

(g) See that a blood sugar test is made following every positive urine test.

(h) Participate in programs for mass surveys promoted by county medical societies, local diabetes associations and the public health department.

Diabetes Detection Drive and Diabetes Week.—Recent surveys have indicated that in addition to the million known diabetics in the United States and Canada there are probably another million whose disease is unrecognized. The American Diabetes Association has undertaken a campaign to find the million unknown diabetics and bring them under treatment. It is widely recognized that early diagnosis and treatment go far toward preventing and development of serious disease and complications. A Nation-wide Detection Drive is under way under the auspices of the Committee on Diabetes Detection of the American Diabetes Association with Dr. Howard F. Root of Boston, Chairman. The drive was officially inaugurated during Diabetes Week, December 6-12, 1948.

There are two immediate objectives. First, to urge upon the public by way of newspapers, radio and other appropriate means the importance of having urinalyses made, especially if there is a family history of diabetes or if obesity is present. Second, to enlist the cooperation of physicians in performing such urinalyses when requested to do so by their patients and relatives. Througout the campaign emphasis is being placed on the all important role of the doctor. In a number of cities in which mass surveys are being conducted with simple methods of detecting sugar in the urine the

results of these urinalyses are not being given to the subjects themselves, but are being sent to physicians designated by them. In other words, every effort is being made to conduct such surveys through the channels of organized medicine.

In Chicago a Committee on Diabetes Detection has been appointed by the Chicago Medical Society and consists of Dr. Robert Keeton, Chairman, Dr. Arthur R. Colwell and Dr. Samuel Soskin. This committee is cooperating with the newly formed Chicago Diabetes Association in furthering the campaign in this area.

HEALTH DEPARTMENT ACTIVITIES

Venereal Disease Institutes.—Three two-day institutes on venereal disease control, sponsored by the Illinois Department of Public Health, were held recently.

The first was scheduled for November 15 and 16 at the Kaskaskia Hotel in LaSalle; the second November 18 and 19 at St. Nicholas Hotel in Springfield; and the third November 23 and 24 at Hotel Emmerson in Mt. Vernon.

Recent advances in the diagnosis and treatment of venereal diseases were outlined at all three institutes, which were open to physicians, nurses, investigators and other persons interested in the control of these infections. Efforts were made to point out the need for education of the general public in the prevention and control of venereal diseases.

Authorities in the special field of venereal diseases participated in the various sessions. Among those scheduled for the LaSalle institute were: Dr. Jack Rodriquez, medical director, Chicago Intensive Treatment Center; Roy Dickerson, executive secretary, Social Hygiene Association, Cincinnati, Ohio; Dr. Edwin W. Hirsch, specialist in urology, Chicago; and Dr. James K. Schafer, assistant medical director for District No. 3, U. S. public health service.

The Springfield institute featured Dr. David Slight, superintendent of the veterans rehabilitation center, state department of public welfare; D. V. Liberti, venereal disease division, U. S. public health service; Dr. H. J. Burstein, veneral disease clinician of Decatur; and Dr. J. H. Shamel, superintendent of health, Springfield.

Among those scheduled for the Mt. Vernon meeting were: Dr. Leland J. Hanchett, medical director, Midwestern Medical Center, St. Louis, and Dr. Arthur Wright Neilson, also of the Midwestern Medical Center; Dr. Herman N. Soloway, venereal disease consultant, state division of industrial hygiene; and Hazel Shortall, chief nursing consultant of the venereal disease division of the U. S. public health service.

Environmental Sanitation Inspectors Urgently Needed.—Addition of 25 new inspectors to the staff of the Chicago Health Department and of nine to that of the Cook County Department of Public Health has been recommended to city and county authorities by the Committee on the Chicago-Cook County Health Survey, Samuel A. Goldsmith, chairman, announced today.

The expansion outlined in health inspection work represents approximately 25 per cent of the total expansion recommended by the experts who made the survey a year ago, it was explained. The committee is sponsored by the Council of Social Agencies of Chicago to work toward the adoption of the recommendations of the Survey in every field of health.

Inspection service in the County Department of Public Health is now on a very small scale, the committee pointed out. The department, which carries responsibility for the health of some 700,000 persons, has only four sanitary engineers and one sanitarian. It needs five sanitarians and four engineers immediately, with more to come in future years.

That would make it possible to place a sanitary engineer and a sanitarian in the branch offices in Harvey, Evergreen Park, Melrose Park and Des Plaines to handle complaints, thereby placing the service on a local basis and improving efficiency by reducing travel time of both inspectors and citizens. Chicago should have in 1949 three new supervisors and 22 field inspectors, to cost a total of $73,272 additional on the 1949 budget.

These men, like the 28 added to the staff a year ago, would devote all their time to food inspection, no matter where, ranging from packing plants to sidewalk displays and vehicles used to transport it, fish and oyster markets, bakeries, and especially restaurants.

Duties of the staff include the education of the restaurant owner or other food business man in the need for cleanliness, the training of food handlers in large classes in the techniques of food handling, the correction and followup of complaints and making routine checks of sanitary conditions.

Their field is technically called "environmental sanitation, since it covers the cleanliness of all factors outside the body that involve health.

In the county outside Chicago, such men would thus cover trailer camps, sewage disposal units such as septic tanks, milk, school luncheons, cesspools and other areas as well as food-handlers.

There are many diseases, the committee pointed out, such as cholera, food poisoning from bacteria, typhoid fever, amebic dysentery and others from which the public is safe only as long as proper inspection of food, water and milk is made.

The State's Health.—During the first 7 months of 1948 the birth rate in Illinois was 20.4 per 1,000 population, a decrease of about 12 per cent from the figures for the corresponding period of 1947, according to a vital statistics report released recently by Dr. Roland R. Cross, state director of public health. Births recorded in the 1948 period totaled 98,951 as against 111,221 last year.

The state's 1948 death rate for the first 7 months was 10.9, also well below that for the 1947 period, when mortality occurred at a rate of 11.5 per 1,000 of the population. The total number of deaths in the 1948 period stood at 52,781 as compared with 54,654 for 7 months of last year.

Particularly noteworthy in the report is the 8 per cent reduction in the rate of death due to causes associated with child-bearing. Up to August 1, 11 maternal deaths for each 10,000 babies born alive were recorded in the State as against a rate of 12 for the same period of 1947.

The report also reveals a further saving in the lives of babies under one year of age. Infant deaths occurred at a rate of 28.9 per 1,000 live births as compared with a rate of 30 in the first 7 months of last year.

Accidents of all kinds dropped slightly during the period, 3,159 as against 3,213. Significant is the fact that 50 deaths due to drowning were reported in the State during July as against 34 deaths in that same month of 1947.

While suicides declined from a total of 545 in the 1947 period to 506 this year, homicides increased from 233 last year to 250 in the first 7 months of 1948.

Population in Welfare Institutions.—The resident population in all institutions of the Department of Public Welfare September 30, 1948 was 47,623, an increase of 1,792 over Spetember 30, 1947. On the books of all institutions, including those present, in family care, conditional discharge, and all absences, were 53,941.

The greatest increase over September of last year was in the nine hospitals for the mentally ill, the population of which rose 1,568. There were 1,074 admissions, 628 discharges and 217 deaths during the month. In these hospitals were 34,494 patients and a total of 37,916 on the books.

The institutions for mental defectives — Dixon State Hospital and Lincoln State School and Colony — showed an increase of 230 over the previous year. The resident population was 9,308, with 10,603 on the books.

There were 365 in Security Hospital. At Neuropsychiatric Institute, where most admissions are temporary for special treatment, 68 patients were present. Of this number, 62 were admitted during the month.

At clinics for trachoma control and prevention of blindness in Southern Illinois, 216 received treatment for trachoma, 58 for glaucoma and 406 for other eye ailments. Thirty were hospitalized for operations.

The Chicago Community Clinic reported 581 interviews. Of these, 572 were former state hospital patients, 242 at Elgin and 211 at Manteno.

The Eye and Ear Infirmary listed 17,649 treatments in September, and 454 persons were admitted to the hospital.

The Welfare Institutions reported 1,494 new dental cases and 4,603 old cases for September.

Report on Venereal Disease.—A Progress Report of the Chicago Veneral Disease Control Program in cooperation with the U. S. Public Health Service has recently been made available. The report covers the period July 1, 1943 to October 31, 1947. The booklet discusses the efforts to uncover cases of venereal disease, the procedures of treatment and a detailed description of the educational work carried on. The booklet is illustrated with photographs, charts and other supplementary data. Dr. Herman N. Bundesen is president of the Chicago Board of Health.

Training Courses for Prospective Parents.—The Illinois department of public health sponsored two in-service training courses in the administration, organization and teaching of classes for prospective parents, Dr. Roland R. Cross, state health officer, announced recently.

Scheduled for October 18 and 19 at the LaSalle Hotel in Chicago, and for October 21 and 22 at the St. Nicholas Hotel in Springfield, these courses were open to physicians, nurses, nutritionists, school administrators and community leaders in health and welfare organizations.

Outstanding authorities in the field of parent education will participate in the sessions. Included among them are: Dr. Edward Graber, lecturer in nursing education, Columbia University and Maternity Center Association, New York City; Dr. Goldie B. Corneliuson, director, bureau of maternal and child health, Michigan department of public health; Dr. Leslie A. Kirkendall, director, Association for Family Living, Chicago; Helen L. McKelvey, supervisor of maternity program, Visiting Nurse Association, Cleveland, and David B. Treat, director, Clara Elizabeth Fund, Flint, Mich.

"Among the first of its kind in the nation, this in-service training has been designed to provide a better understanding of the objectives of education for parenthood," Dr. Cross said. "Emphasis will be placed not only on various aspects of care for pregnant mothers, but also on the value of guidance to parents in caring for small children."

MARRIAGES

Henry C. Scholer to Miss Dorothy Eyler, both of Monmouth, October 16, Miss Eyler was employed in the Office of the Secretary of the Illinois State Medical Society for six years prior to her marriage.

Robert Lowell Dame, Rockford, to Miss Jean Thompson, Joliet, recently.

W. Robert Elghammer, Chicago, to Miss Doris Elizabeth Postlewaite, Palatine, recently.

Mark C. Guinan, Chicago, to Amy Doris Holmberg, in Chicago, recently.

DEATHS

Theodore C. F. Abel, Chicago, who graduated at Jenner Medical College, Chicago, in 1903, died October

19 aged 83, from injuries received when he was run into by a bus. He was medical director of the Abel Laboratories.

Bernard P. Conway, Chicago, who graduated at Chicago College of Medicine and Surgery in 1914, died November 4, aged 61. He was Supreme Medical Examiner of the Royal League.

Nettie Austin M. Dorris, formerly of Paris, Illinois, who graduated at University of Louisville School of Medicine in 1905, died at Cottage Hospital, Galesburg, aged 71. She was superintendent of Illinois Mobile Health Unit.

Robert Edward Dyer, Chicago, who graduated at the University of Illinois College of Medicine in 1919, died of a heart attack October 29, aged 55. He was a member of the surgical staff of Ravenswood Hospital.

Arthur C. Gronwold, retired, Chicago, who graduated at Bennett College of Eclectic Medicine and Surgery, Chicago, in 1906, died in his home of a heart attack, October 10, aged 66. He served 12 years on the staff of the Norwegian-American Hospital.

Dr. Alonzo Hall, Niantic, who graduated at the University of Illinois College of Medicine in 1895, died October 6, aged 88, after an illness of several months. He had practiced medicine in Niantic over 60 years.

Wilbur Vogt Johnson, Chicago, who graduated at the College of Physicians ad Surgeons of Chicago, School of Medicine of the University of Illinois in 1902, died in the Belmont Hospital, August 29, aged 70, of carcinoma of the stomach.

Thomas Alfred Jones, Menard, who graduated at Marion-Sims College of Medicine, St. Louis, in 1897, died in Evanston, July 3, age 79, of carcinoma of the signoid.

Albert Rankin Martin, Chicago, who graduated at Rush Medical College in 1892, died October 15, aged 87. He was a member of the staff of St. Mary of Nazareth Hospital for 30 years.

Warren G. Murray, Dixon, who graduated at Ohio Medical University, Columbus, in 1906, died suddenly at the Mayo clinic in Rochester, October 13, aged 66. He was managing officer of the Dixon State Hospital for 26 years and an authority on mental diseases.

Oscar J. Nothinberg, Chicago, who graduated at Dearborn Medical College, Chicago, in 1907, died November 9, aged 74. He was professor of otolaryngology at Chicago, Eye, Ear, Nose and Throat College for many years and on the staff of Swedish Covenant Hospital.

Ray Randle Osborne, Rockford, who graduated at Chicago College of Medicine and Surgery in 1912, died October 24, aged 66. He had practiced medicine in Rockford since 1921.

Gardner Shaw Reynolds, formerly of Danville, who graduated at University of Minnesota Medical School in 1924, died October 16, aged 50, in St. Paul, Minn., where he formerly lived. He was radiologist at St. Elizabeth Hospital, Danville, until his retirement last spring.

Henry Tetrev, Berwyn, who graduated at Chicago College of Medicine and Surgery in 1908, died November 7 in his home, aged 70. He had practiced medicine in Chicago for 40 years.

Wesley Munger Thomas, Westville, Indiana, formerly of Chicago, who graduated at Chicago Homeopathic Medical College in 1895, died October 21, aged 80. He had practiced medicine in Chicago more than 50 years.

Ernest C. White, Chicago, who graduated at Dunham Medical College in 1902, died October 14 of a heart attack, aged 69. He was medical superintendent of Alexian Brothers Hospital for the last six years.

Bert G. Wilcox, Joliet, who graduated at Chicago College of Medicine and Surgery in 1912, died November 3, aged 68, at the Mayo clinic, Rochester. He was chief of staff of Silver Cross Hospital and also on the staff at St. Joseph's Hospital, Joliet.

Benzion Wolf, Chicago, who graduated at Bennett Medical College, Chicago, in 1914, died August 14, aged 64, of carcinoma of the pancreas.

James McClain Young, Annawan, who graduated at St. Louis University School of Medicine in 1905, died October 17, aged 67, after an illness of about ten months. He had practiced medicine in Annawan for 33 years.

"For The Common Good"

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society; Robert S. Berghoff, Chicago, Chairman; Louis Limarzi, Chicago, Vice Chairman:

Edward F. Rosenberg, Chicago, Henry County Medical Society in Kewanee, November 18, on Chronic Arthritis, Differential Diagnosis and Present Concepts of Therapy.

Leo K. Campbell, Chicago, McHenry County Medical Society in Crystal Lake, November 18, Management of Diabetes Complicated by Surgery, Obstetrics and Acidosis.

Theodore Van Dellen and Percy E. Hopkins, both of Chicago, Fulton County Medical Society, December 10, in Canton, on Coronary Heart Disease and Compulsory Health Insurance, respectively.

Leo K. Campbell, Chicago, Henry County Medical Society in Kewanee, January 13, on Diabetes.

John W. Ferrin, Chicago, McHenry Medical Society in Crystal Lake, January 20, on Endocrine Management of Prostatic Cancer.

Samuel M. Feinberg, Chicago, Will-Grundy County Medical Society in Joliet, January 27, on Allergy Therapy for the Non-Specialist.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society; Charles P. Blair, Monmouth, Chairman: Warren W. Furey, Chicago, Vice Chairman:

Marvin Lerner, Chicago, West Side YWCA, November 2, narrator with film Human Reproduction.

Mr. John Bach, director, press relations, AMA, Associated Clubs and Churches in Chicago, November 8, Pickpocket Medicine.

E. C. Turner, Savanna, Woman's Auxiliary, Rock Island County Medical Society in Rock Island, November 9, Socialized Medicine.

Mr. John W. Neal, Chicago, Woman's Auxiliary to Chicago Medical Society in Chicago, November 9, Medical Legislative Problems for the Coming Year.

Mr. John Bach, AMA, North Central Medical Association in Princeton, November 11, Pickpocket Medicine.

Warren H. Cole, Chicago, Federation of Employees' Benefit Association in Chicago, November 18, Socialized Medicine in Great Britain.

Ernst Schmidhofer, Ramblers of the Ravenswood Methodist Church in Chicago, November 21, Living Clinical Material on Psychosomatic Medicine and film on Therapeutic Relaxation.

Morris Friedell, Chicago, Lawn Manor Community Center Men's Club in Chicago, December 1, Cancer in the Male.

Chester Coggeshall, Chicago, Woman's Auxiliary, South Chicago Branch, Chicago Medical Society, December 6, Early Detection of Diabetes.

Warren H. Cole, Woman's Auxiliary, Chicago Medical Society, December 14, The Doctor and the Patient in Great Britian.

Spencer School PTA in Chicago, January 13, film When Bobby Goes to School.

George Wakerlin, Chicago, Illinois Federation of Women's Clubs, Public Health Chairman, in Chicago, January 10, Animal Experimentation versus Anti-Vivisection.

Philip Rosenblum, Chicago, Clara Barton PTA in Chicago, January 13, on Emotional Behavior in Children.

W. W. Bolton, AMA, Chicago, William Howard Taft PTA, in Chicago, January 17, on Good Health Habits for Teen Agers.

Mary G. Schroeder, Chicago, Gage Park Woman's Club in Chicago, January 25, on Growing Old Gracefully.

Postgraduate Conference for First Councilor District arranged Through the Postgraduate Education Committee; Robert S. Berghoff, Chairman; George Hellmuth, Chicago, Vice Chairman. The conference was held in Rockford at the Hotel Faust, November 10, with Dr. Alexander Braze, Rockford, president of the Winnebago County Medical Society, presiding. The following Chicago physicians participated:

Henry G. Poncher, Therapy in Infancy and Childhood.

Ralph Bettman, Intrathoracic Surgery, illustrated.

Paul S. Rhoads, Inhalation of Penicillin Dust: Proper Role in Infections of the Respiratory Tract, illustrated.

The dinner speakers were Dr. Percy E. Hopkins, President of the Illinois State Medical Society, on Voluntary Prepayment Medical Care, and Dr. Percival Bailey, Japanese B. Encephalitis.

Conference for the Fifth Councilor District was held in Pekin, December 9, with Dr. Ralph P. Peairs, Normal, Councilor for the District presiding and with the Tazewell County Medical Society acting as host. The following Chicago physicians spoke:

William T. Carlisle, Forewarning and Forearming in Obstetrics, illustrated.

Chauncey C. Maher, Management of Cardiac Patients Pre- and Post-Operatively.

H. William Elghammer, Advances in Pediatrics.

In the evening Dr. Percy E. Hopkins, president of the state medical society, discussed Voluntary Prepayment Medical Care, and Dr. Chester C. Guy, Bleeding Peptic Ulcer.

THIOCYANATE THERAPY NOT UNIFORMLY GOOD

Use of potassium thiocyanate in treating patients with high blood pressure does not produce uniformly good results, say two Chicago physicians.

Writing in the October 23 issue of The Journal of the American Medical Association, the physicians — Donald L. Kessler and Laurence E. Hines of the Departments of Medicine, Northwestern University and St. Joseph Hospital — report that the drug may or may not produce a fall in blood pressure in patients who have hypertension.

There appears to be a narrow margin of safety between therapeutic and toxic doses in some patients, and moderate toxic symptoms are common even when the dosage given is that recommended as "safe," they point out.

The physicians describe three patients who suffered "unusual toxic effects" while receiving thiocyanate therapy for high blood pressure.

For awhile we felt sympathy for the poor male ant whose life ended shortly after mating, now that feeling is all changed. He becomes the father of some twenty-five thousand offsprings in just one try — that's enough to make any parent want to retire permanently. — *The Friendly Adventurer, Oct.,* '48.

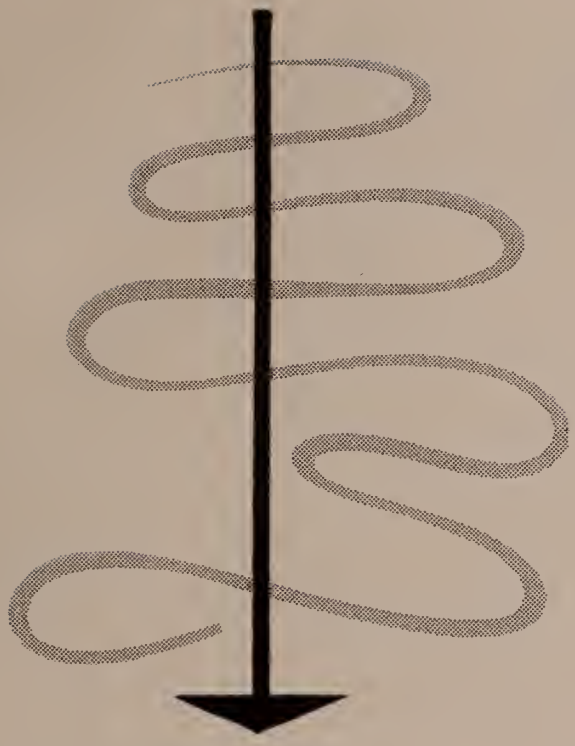
It has been estimated that nearly four per cent of all persons who visit physicians' offices complain of cough or expectoration. The alert physician will insist upon a sputum examination of all such patients. Such practice will be awarded by the discovery of tubercle bacilli in three or four out of every 100 specimens examined. The family doctor will fairly often discover to his astonishment that a patient with slowly resolving pneumonia has an acid-fast reason for prolonged convalescence. Herman E. Hilleboe, M.D., Journal-Lancet, June, 1947.

TEST SENSITIVITY TO STREPTOMYCIN

Few patients have allergic reactions to streptomycin ointment, report Leon Goldman, M.D., and Milton D. Feldman, M.D., of the Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati, Cincinnati, Ohio.

The physicians describe their findings in the October 30 issue of The Journal of the American Medical Association.

Not one of 212 persons tested by the physicians showed sensitivity to streptomycin ointment. In a series of 300 patients treated with streptomycin ointment, only three developed skin rash from the drug. The ointment is valuable in treating superficial skin infections, the study shows.



direct route

Whenever oral vitamin B complex therapy seems ineffective, Ampoules 'Betalin Complex' (Vitamin B Complex, Lilly) are recommended for intravenous or intramuscular use in doses of 1 to 4 cc. daily. The *direct route* assures complete utilization. Impaired absorption is circumvented, and large amounts of the B complex vitamins are immediately available.



'Betalin Complex' is a prepared solution containing in each cc.:

Thiamin Chloride	5 mg.
Riboflavin	2 mg.
Nicotinamide	75 mg.
Pantothenic Acid (as Calcium Pantothenate)	2.5 mg.
Pyridoxine Hydrochloride	5 mg.

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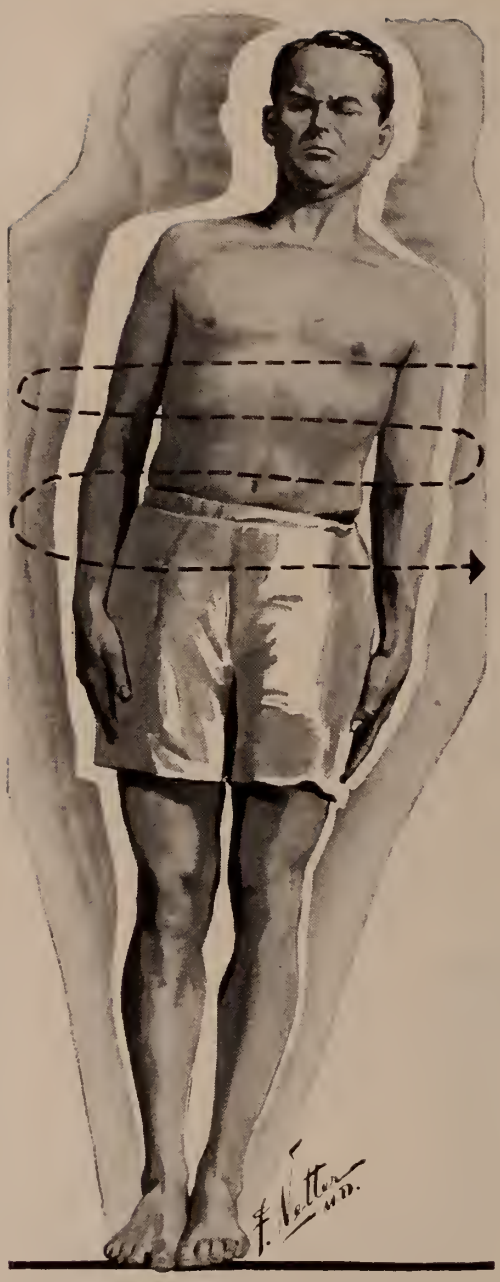
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LOW INDEX OF ALLERGENICITY—Bacitracin is outstanding in that its application topically is only rarely complicated by allergic manifestations. It therefore possesses a distinct advantage over many other antibiotics, freeing topical antibiotic therapy from this formerly serious limitation.

WIDE RANGE OF EFFECTIVENESS—While its spectrum of action largely parallels that of penicillin, Bacitracin is destructive to many strains of pathogens which are penicillin-fast. Thus it broadens the scope of antibiotic therapy and enhances its therapeutic efficacy.

PROMPT ACTION—Injected in solution into the base of pyogenic lesions, or applied topically in the form of an ointment, Bacitracin acts promptly upon the bacterial invasion. Response is apparent in most cases within a short period.

INDICATIONS—Bacitracin, topically administered, is indicated in the treatment of many deep pyogenic lesions of the skin, superficial cutaneous pyogenic lesions, and many external ocular infections due to Bacitracin-sensitive organisms. Bacitracin is administered topically only.

Bacitracin, in dry form for making solutions, is supplied in 20 cc. serum-type vials containing 2,000 and 10,000 units, and in 50 cc. vials containing 50,000 units. Also available as Bacitracin Ophthalmic Ointment in ⅛ ounce tubes and as Bacitracin Ointment in ½ ounce tubes, both containing 500 units per Gm. Literature available to physicians on request.

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For such patients, as for *all* smokers, the choice should be the least irritating of cigarettes. Many throat specialists suggest Philip Morris* because they are convinced from published studies**, as well as *their own observations* that Philip Morris alone, of all the leading cigarettes, is by far the least irritating to the sensitive tissues of the nose and throat.

Perhaps you too will find it advisable to suggest to your patients who smoke . . ."Change to Philip Morris."

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Loryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Loryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

PHYSICAL MEDICINE ABSTRACTS

JOHN S. COULTER, Department Editor



ISOTOPES AND RADIATION HAZARDS

Frank Howarth, M.B., Manc., D.P.M. From the Department of Pharmacology, University of Manchester. THE LANCET LONDON, No. 2 of Vol. 2, 1948. No. 6515. Vol. CCLV. Page 51. July 10, 1948.

It is to be emphasied that, in human experimentation, there is no excuse for using an isotope technic when some ordinary chemical procedure would suffice. If the problem will not yield to a chemical approach, it is desirable before using a radioactive isotope to consider the possibilities offered by a stable isotope which can be readily detected and, with the exception of deuterium, can be administered, adlib, without biological effect. Radiophosphorus should not be used in the treatment of patients in the reproductive period of life, or who have an expectation of life of five years or more (*British Medical Jr.* 1947).

Isotope work is totally unsuited to a general laboratory such as the clinical laboratory of a hospital. Unless special precautions are taken, the benches, sinks, and furniture can become heavily contaminated with radioactive materials; and, if elements of long half-life, such as Co^{60}, Sr^{89}, or Zn^{65}, are used, the accumulated radiation may soon reach a dangerous level. Excellent accounts of laboratory hazards and the means for reducing them have been given by Sullivan (1947) and in some textbooks on radium.

Finally, those intending to employ radioactive isotopes for clinical purposes should make contact with the isotope section of the Medical Research Council, where advice from experts is readily available.

RADIOACTIVE ISOTOPES IN MEDICINE

T. Swann Harding, Falls Church, Va. In MEDICAL RECORD, June-July, 1948. Vol. 161, No. 6/7. Page 326.

Stable isotopes are not radioactive and usually have to be recognized by use of the spectrometer. But, by suitable combinations of radio-active and stable isotopic atoms in molecules it may prove possible to follow their chemical mutations with greater accuracy. Heavy water, carbon 13, and nitrogen 15 are prominent representatives of interesting and useful stable isotopes.

It may also be well to avoid the use of long-lived isotopes like carbon 14, in tracer experiments involving human beings, because of its dangerous emission of alpha particles, and to use nonradioactive carbon 13 instead. In general, radioactive isotopes with shorter half-life, especially those that emit beta rays—as well as some which emit gamma, may be used safely in dosages too small to have an observable biological effect but sufficiently large to be traced and thus useful in biological experimentation.

(*Continued on page 46*)

Orapen-250

It is now possible to give 250,000 units of crystalline penicillin G (potassium salt) in one coated, pleasant-tasting, buffered tablet, if you specify the Schenley product. Ample evidence supports the value of the oral administration of penicillin when given in sufficiently high dosage. Clinical reports show that even serious infections due to penicillin-sensitive organisms—such as acute respiratory illness,[1,2,3,4] impetigo,[4] gonorrhea,[5] and rheumatic fever (prophylaxis)[6]—can be treated effectively by this convenient, painless method of administration.

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REFERENCES:

1. J. Pediat. 32:1 (1948).
2. Am. J. M. Sc. 213:513 (1947).
3. J. Pediat. 32:119 (1948).
4. New England J. Med. 236:817 (1947).
5. New York State J. Med. 48:517 (1948).
6. Lancet 1:255 (1947).

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Physical Medicine (Continued)

ISOTOPES IN CLINICAL AND EXPERIMENTAL MEDICINE

Ellsworth C. Dougherty, Ph.D., M.D. and John H. Lawrence, M.D., Sc.D., Berkeley. In CALIFORNIA MEDICINE. July, 1948, Vol. 69, No. 1, Page 58.

In summary it may be observed that the role in therapy of radioactive isotopes and of those stable species that can also be adapted to the production of ionization in tissues is still in a primitive stage of development. Unquestionably, the future will see great expansion in our knowledge of their usefulness and practical application. The use of the new types of radioactivity must, however, be approached with caution. It has long been known that ionizing radiation in addition to its acute effects may have such chronic manifestation as the induction of malignant change in tissue. Radium-induced bone sarcomata have been observed for many years. Recently, Lisco, Finkel and Brues have shown that both radiostrontium — SR and plutonium — Pu — can produce bone tumors in mice, particularly the former. This has particular significance for the possible use in man of long-lived isotopes of elements that concentrate in bone — as for example, many of the fission product elements.

PROSTATITIS: ESPECIALLY AS IT RELATES TO CAUSE, TREATMENT AND SIGNIFICANCE

Roy B. Henline, M.D., New York, N. Y. In THE NEBRASKA STATE MEDICAL JOURNAL. August 1948. Vol. 33, No. 8, Page 266.

Acute prostatitis, whatever the cause, is best treated by complete bed rest for all febrile cases and the avoidance of foods which irritate the urinary tract. Sexual excitation should be avoided, and all local treatment, such as urethral or bladder irrigations and rectal manipulation, should be discontinued. Heat is beneficial and may be obtained by hot sitz baths. The bowels should be kept well open to avoid the pressure of a hard stool against the prostate. Only the most gentle palpation should be done to diagnose the development of a prostatic abscess.

Local Treatment. — Once the diagnosis of

(Continued on page 48)

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FORMULA—Each teospoonful (5 cc.) represents:
Alcohol (by volume).....12 %
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Physical Medicine (Continued)

chronic prostatitis has been established, massage of the prostate by the rectum is the most important single measure to be employed in its treatment.

THE TREATMENT OF INFANTILE PARALYSIS DURING THE ACUTE STAGE

Philip Lewin, M.D. Chicago. In THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION, September, 1948, Vol. 41, No. 9, Page 908.

As soon as the diagnosis of infantile paralysis is proved or strongly suspected treatment should be started.

Rest: Rest is the one great essential in the immediate care.

Application Of External Heat: Extremities should be kept warm.

Gentle passive exercises are given, but never to the point of pain.

Primary Splinting: Any recognized type of splint which will maintain neutral positions can be used.

Nursing Care: The patient must be kept in bed, with physical and mental quiet. To preserve rigidity and prevent sagging, several boards or a wood frame may be placed under one or two mattresses.

Treatment By Warm Sea Salt Baths: Warm sea baths alleviate muscle and nerve pain. In some instances they may be started very cautiously within seven days after the onset of the disease.

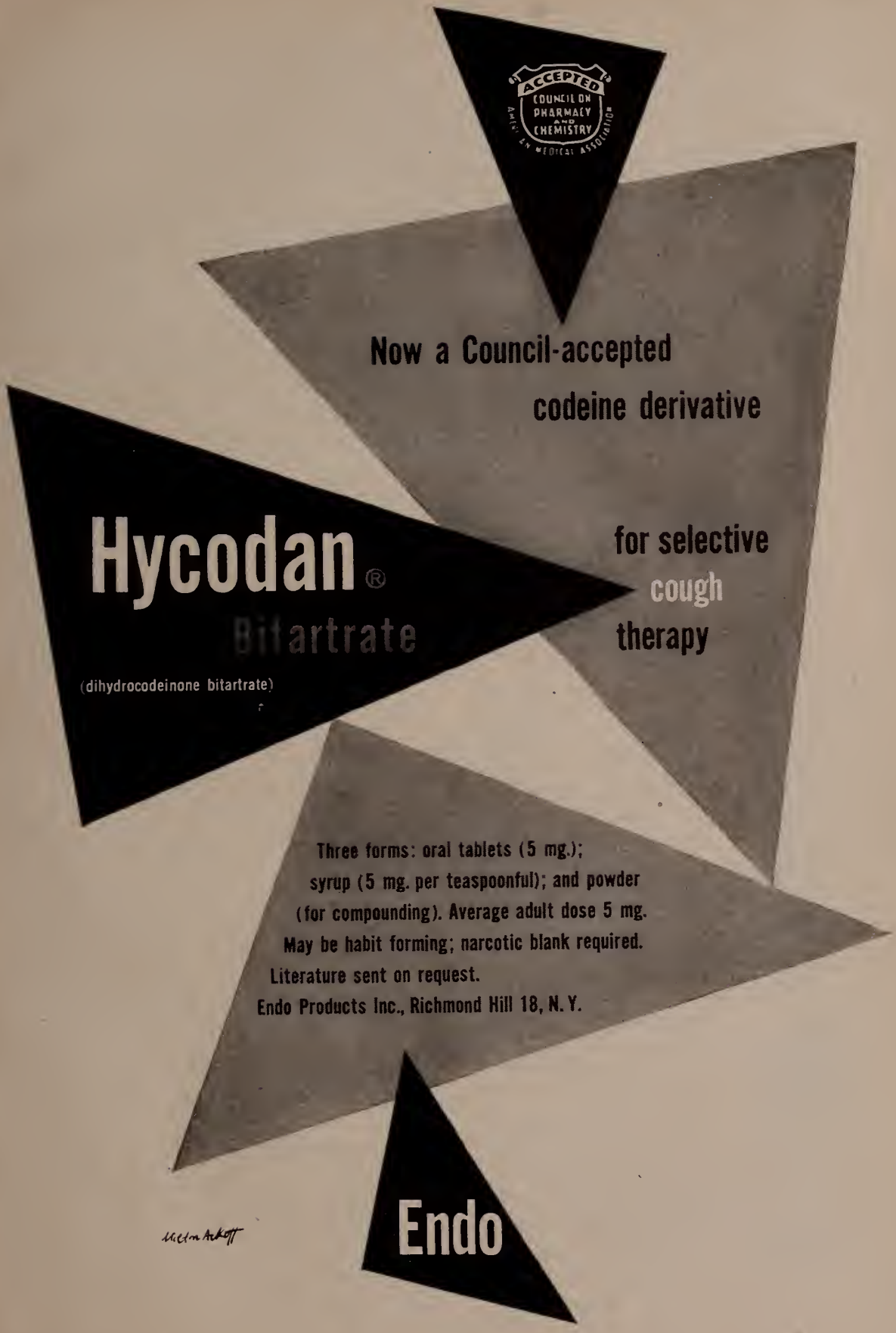
Physical Therapy After The Acute Stage: Attention should be directed to the prevention of deformities by means of rest in proper positions, with constant supervision of the most minute details.

The less patients are handled in the early stages, the better the results will be.

The majority of patients are kept off their feet from ten to twelve months before they are allowed to attempt to stand or walk even the support of braces and crutches. If, however, a patient is very slightly affected, his activities will depend largely on the return of power to the muscles of his trunk, pelvis and lower extremities. He would probably be kept off his feet for at least six months.

Overuse of an affected limb is harmful.

(*Continued on page* 50)


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Hycodan®
Bitartrate
(dihydrocodeinone bitartrate)
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May be habit forming; narcotic blank required.
Literature sent on request.
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Physical Medicine (Continued)

Assisted Movements: Muscle training consists in aiding the patient to perform a certain movement, in the hope of stimulating an impulse for the movement from the brain to the weakened or paralyzed muscle.

Underwater treatment has been an important advance in handling poliomyelitis patients.

Light massage, if given by a person especially trained in the aftercare of infantile paralysis, is valuable.

Braces: A brace is a mechanical support whose purpose is to maintain a certain position of a portion of the body.

BOXER'S BURSITIS

A. Waxman, M.D., and H. Geshelm, M.D., Los Angeles, In: CALIFORNIA MEDICINE, September, 1948, Vol. 69, No. 3, Page 203.

1. (a) In a five-year period during which 523 injuries to professional and amateur boxers and wrestlers were treated, traumatic bursitis of the metacarpo-phalangeal joints of the hand was diagnosed in ten instances. (b) The diagnosis of bursitis was confirmed by aspiration of bloody or gelatinous fluid from the affected bursa. (c) The lesion occurred particularly in Negro pugilists following knuckle injuries. (d) Review of the literature indicates that this is a relatively rare disease.
2. These cases were among 22 knuckle injuries treated during the same period, 12 of the 22 (nine in Caucasians and three in Negroes) having been simple contusions which were completely reduced in a few days of treatment with hot soaks.
3. Conservative treatment in seven of the cases of bursitis, consisting of aspiration of the bursea, hot soaks, and adhesive strapping and physical therapy, resulted in clinical cure. In the remaining three the bursal sac was excised and clinical cure followed.
4. Reports of the cases in which the bursal sac was removed are made in detail.

PHYSICAL RECONDITIONING IN JAPAN

Captain Noel H. Petree, Medical Service Corps, Army of the United States. The BULLETIN OF THE U. S. ARMY MEDICAL DEPARTMENT. Vol. VII. No. 7: 547. July, 1948.

Physical reconditioning has contributed to the speedier return of military patients to usefulness

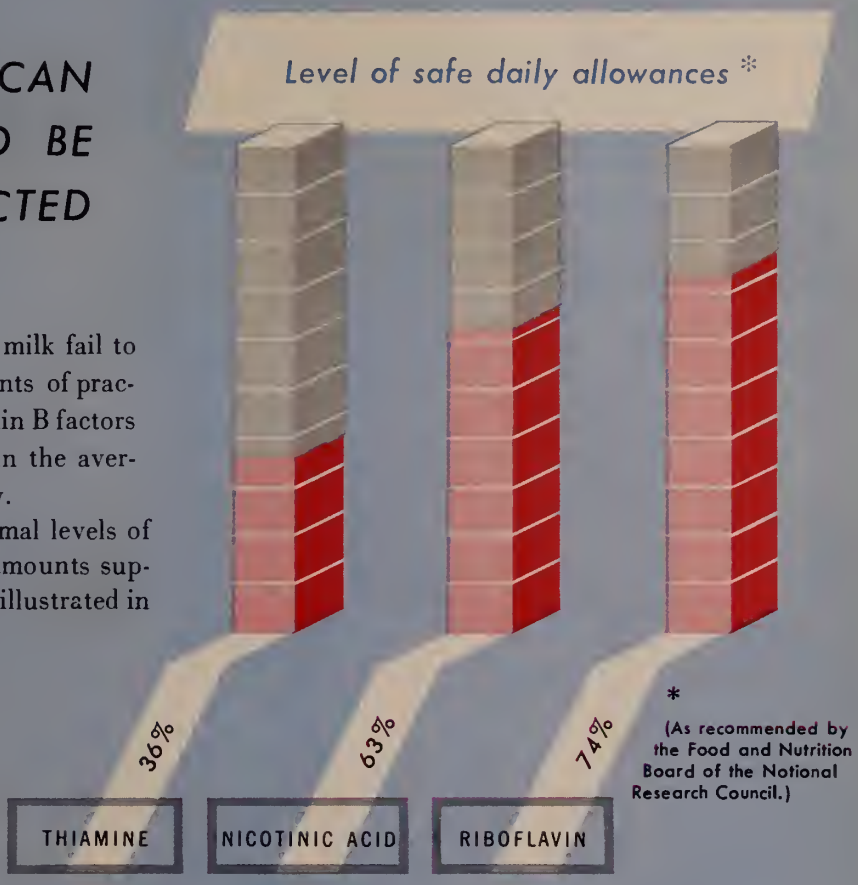
(Continued on page 54)

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. . . THEY CAN AND SHOULD BE CORRECTED

BOTH human and cow's milk fail to provide sufficient amounts of practically all essential vitamin B factors for optimum nutrition in the average diet of early infancy.

The gap between optimal levels of these vitamins and the amounts supplied by human milk is illustrated in the chart to the right.



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Thiamine Hydrochloride	1.0 milligram
Riboflavin	0.4 milligrams
Pyridoxine Hydrochloride	1.0 milligram
Sodium Pantothenate	2.0 milligrams
Nicotinamide	10.0 milligrams
Ascorbic Acid	50.0 milligrams

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1. Cook, J.V.: Brenneman Practice of Ped. 4: Chapter 41, 1945.
2. Benson, R.A. et al: J. Ped. 31:369-754, 1947.
3. Perlman, H.H.: Skin & Cancer Clinic, Post Graduate Hospital, New York, 1948.

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Physical Medicine (Continued)

in Japan. The full realization of the importance of exercise with respect to specific and general disabilities will be advanced through (1) assigning to full-time duty officer and enlisted personnel trained in technics and knowledge of physical reconditioning that will enable medical staffs to transmit prescriptions for exercise in precise dosage; (2) defining the areas to be treated by physical therapy, occupational therapy and physical reconditioning; and (3) setting up lower levels of exercise that may invite medical officers to direct earlier assignment of patients to the physical reconditioning program.

THE ROLE OF PHYSIOTHERAPY IN THE TREATMENT OF POLIOMYELITIS

F. S. Cooksey, O.B.E., M.D. PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE. Vol. XLI: 395. June 1948.

Treatment In The Stage Of Chronic Disability

Some time between six months and two years it becomes obvious that no further improvement is likely to be obtained in the weak muscles by graduated exercise. This is always a difficult decision to take and the point is reached so gradually that it is apt to be overlooked with the result that the expectant treatment is continued too long with unnecessary financial hardship to the patient. I think a physical therapist who has been coaxing weak muscles for many months is liable to underestimate the degree of recovery at this stage and consequently it is important for the medical practitioner to check the voluntary power record frequently at this period.

In the spring a young man's fancy but a young woman's fancier.

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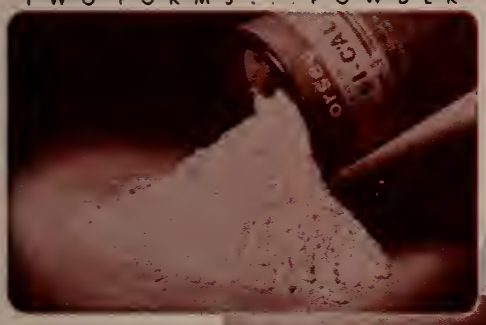
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BOOK REVIEWS



TREATMENT BY DIET, by Clifford J. Barborka, B.S., M.S., M.D., D.Sc., F.A.C.P. Assistant Professor of Medicine, Northwestern University Medical School; Attending Physician, Passavant Memorial Hospital; Consultant in Gastro-enterology and Gastroscopy, Diagnostic Center, Hines Veterans Hospital; Formerly Consulting Physician, Mayo Clinic. 5th Ed. 784 pages. 1948. J. P. Lippincott Co., Philadelphia. $10.00.

The previous editions of this book were favorably reviewed in these columns and the new edition continues the same high standards. The practitioner should know enough dietetics so that he does not have to relegate this popular and important form of treatment entirely to dietician and cook. Doctor Barborka's book remains a valuable aid in this connection.

J. C. S.

TREATMENT OF MALIGNANT DISEASE BY RADIUM AND X-RAY: By Ralston Patterson, M.C., M.D., F.R.C.S.E., D.M.R.E., F.F.R., Christie Hospital & Holt Radium Institute, Manchester. The Williams & Wilkins Co., Baltimore 1948. Price $11.00.

The author's statement in the introduction to this volume that the scope of this book is most aptly described as a "Practise" of radiotherapy is certainly borne out with study of its content.

The methods of radiotherapy described are those used in the radium institute in Manchester, England.

The 34 chapters of this book embrace treatment policy, techniques of application of x-ray and radium, dosages, more detailed management of malignant disease in all systems and organs, causes of failure of treatment, organization plans for departments of radiotherapy, and some information concerning new radiotherapeutic agents. Radium dosage charts are included as an appendix.

Any discussion of radiation physics and statistics concerning results have been purposely omitted.

The volume is of particular interest to the radiotherapist as a reference and contains much valuable information concerning the construction of various radium applicators.

For the practitioner seeing an occasional case of malignant disease, information pertinent to specific management, value of team work during treatment, and measures of care and expectancy are included.

The work is well written, generously illustrated and complete to the author's intent.

A worthwhile addition to a medical library.

J. H. G.

MODERN DERMATOLOGY AND SYPHILOLOGY: By S. William Becker, M.D., Clinical Professor of Dermatology, University of Chicago, and Maximilian E. Obermayer, M.D., Clinical Professor and Chairman of the Department of Dermatology, University of Southern California. Second Edition. 1017 pages, 461 illustrations, 37 color plates. J. B. Lippincott Company, Philadelphia, 1947. Price $18.00.

The second edition of this inclusive text has been enlarged and revised and many new additions are to be found. Presentation of the material in the informal style of the lecturer continues to make this text quite readable. Arrangement of the contents from the functional standpoint plus the brief orientation introducing each chapter enhances its value and interest to the reader.

In the chapter on dermatologic diagnosis, the authors present several fixing and staining methods including one in which dioxan is used to speed the process without loss of quality.

The chapter on therapy and formulary has been en-

(*Continued on page* 58)

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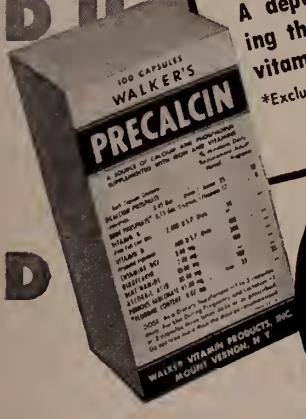
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Book Reviews (Continued)

larged. New preparations are included and formulas are given for useful compounds.

The general text is most comprehensive and the clinical descriptions are augmented by numerous illustrations many of which are original. Additions and revisions are evident in the chapters on pigmentary disturbances, on trophic and deficiency diseases and on lepra.

Chapters 38 through 57 consider syphilis in all its ramifications. This section contains much useful and practical information. Readers must realize, however, that progress in syphilotherapy is so rapid at present that texts covering this phase are prone to be dated soon after leaving the press.

This edition is superior to the previous one giving students and practitioners alike complete and detailed information. Numerous references facilitate further investigation of the topics covered.

D. F. R.

Textbook of Gynecology: By Emil Novak, M. D., F.A.C.S., Assistant Professor of Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore. The Williams & Wilkins Company, Baltimore, 1948. Third Edition. 742 pages. Price $8.00.

This textbook of gynecology is an up to date presentation intended primarily for the general physician and student. A large amount of gynecological material is presented in a practical way without burdening the reader with elaborate discussions suitable only for the specialist. The title has been changed from the previous two editions due to the incorporation of endocrinology as an integral part of gynecology. The book has been written from two aspects: the conventional way of discussing anatomy, embryology, history-taking, etc., and a more detailed discussion of the functional disorders occurring in the female. Diagnosis and therapy are the main themes of the book. Diagnosis is enhanced by concisely covering the practical essentials and profusely illustrating them with sketches, drawings, photographs, both microscopic and gross. Color photographs are included where this is important to emphasize diagnostic points. Numerous changes have been made from previous additions chiefly in minor additions. The book is well written and may be used as a useful reference text.

J.W.F.

Clinical Diagnosis by Laboratory Methods (A Working Manual of Clinical Pathology): By James Campbell Todd, Ph.B., M.D., Late Professor of Clinical Pathology, University of Colorado School of Medicine. Arthur Hawley Sanford, A.M., M.D., Professor of Clinical Pathology, Mayo Foundation,

(*Continued on page* 60)

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Book Reviews (Continued)

University of Minnesota; Senior Consultant, Division of Clinical Laboratories, The Mayo Clinic. With the collaboration of George Giles Stilwell, A.B., M. D., Division of Clinical Laboratories, the Mayo Clinic. Eleventh Edition. W. B. Saunders Company, London and Philadelphia. 1948. 954 Pages. Price $7.50.

The eleventh edition of this textbook of laboratory methods attests to its authoritativeness in keeping with the modern advance of medicine. This book has established itself as an essential reference for the student as well as the practitioner. This edition has been very much rewritten and amplified in quite some detail especially in the chapters on vaccines, mycology, antibiotics, and skin testing with biological substances. The diagnosis of diseases by serology has been particularly broadened. The book is easily read with little difficulty in locating subjects in question. The many illustrations clarify the subjects presented and where necessary colored plates of unusual reproduction are used. The fundamentals of biochemistry are presented in clinical fashion enabling the reader to understand the reason for certain tests. For supplemental reading a bibliography concludes each chapter. This textbook has been and continues to be, a necessary part of the medical library, and in so far as a textbook can be the latest thing, this presentation brings one abreast of current laboratory-clinical medicine.

J.W.F.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HUMAN BIOCHEMISTRY: Second Edition By Israel S. Kleiner, Ph. D., Professor of Biochemistry and Director of the Department of Physiology and Biochemistry, New York Medical College, Flower and Fifth Avenue Hospitals, formerly Associate, The Rockefeller Institute for Medical Research, New York; Seventy-seven text illustrations and five color plates. The C. V. Mosby Company, St. Louis, 1948; 649 pages; $7.00.

A DOCTOR TALKS TO TEEN-AGERS, a Psychiatrist's Advice to Youth; By William S. Sadler, M.D., F.A.P.A., Chicago, Consulting Psychiatrist, Columbus Hospital, Fellow of the American Psychiatric Association, The American Medical Association, The American Association for the Advancement of Science, Member of the American Psychopathological Association; The C. V. Mosby Company, St. Louis, 1948; 379 pages; $4.00.

SYNOPSIS OF PSYCHOSOMATIC DIAGNOSIS AND TREATMENT: By Flanders Dunbard, M.D., with the as-

(*Continued on page* 64)



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Classified Advertisements 68

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Coca Cola, Atlanta, Ga. 60
Knox Gelatin Laboratories, Johnston, N. Y.
Libby, McNeil & Libby, Chicago 9
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover
National Dairy Products, New York, N. Y.
Nestle's Milk Products, Inc., 155 E. 44th St., New York 17
Swift & Co., Chicago 47
Wander Company, 360 N. Michigan Ave., Chicago

FINANCIAL AND INSURANCE

Medical Protective Co., Fort Wayne, Ind. 21
Physician Casualty Co., Omaha, Neb. 48

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 22
Ames Co., Inc., Elkhart, Ind.
Arlington Chemical Co., Yonkers 1, N. Y. 10, 46
Armour Laboratories, Chicago 9, Ill. 40
Ayerst, McKenna & Harrison Ltd., New York 16 27
Baybank Pharmaceuticals, New York 4
Borcherdt Malt Extract Co., Chicago 12, Ill.
Bristol Laboratories, Inc., Syracuse 1, N. Y. 25
Bristol-Meyers Co., New York
Ciba Company, Summit, N. J. 4, 63
Commercial Solvents Corp., Terre Haute, Ind. 11, 41
Crookes Laboratories, Inc., 305 E. 45th St., N. Y.
Doho Chemical Corp., New York 13, N. Y. 59
Durex Products, New York
Endo Products, Inc., Richmond Hill 18, N. Y. 49
Otis E. Glidden & Co., Evanston
Gold Pharmacal Co., New York 67
Hoffman-LaRoche, Inc., Nutley, N. J. 3
Holland-Rantos Co., Inc., 551 Fifth Ave., New York
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Lily, Eli & Co., Indianapolis, Ind. 35, 36, 37
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McNeil Laboratories, Inc., Philadelphia, Pa.
Merck & Co., Rahway, N. J. 16
Morris, Philip & Co., 119 Fifth Ave., New York 43
Nepera Chemical, Yonkers, N. Y. 32
Num Specialty Co., Pittsburgh, Pa. 66
Parke, Davis & Co., Detroit, Mich. 13
Plastishield, Inc., Minneapolis 2, Minn.
Rare Chemicals, Inc., Flemington, N. J.
Reed & Carnrick, Jersey City 6, N. J.
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Schering Corp., Bloomfield, N. J. 31
Schmid, Julius, Inc., 423 W. 55th St., New York City .. 38
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Sharp & Dohme, 11 Canal St., Chicago 8
The Smith Dorsey Co., Lincoln, Nebr. 55
Smith, Kline & French, Philadelphia 6, 23, 34, 39, 61
E. R. Squibbs & Co. 33
The Tarbonis Co., Cleveland 3, Ohio 42
Upjohn Co., Kalamazoo, Mich. 17
Walker Vitamin Products, Inc., New York 57
Wm. R. Warner & Co., 113 W. 18th St., New York 29
Warren-Teed Products Co., Columbus 8, Ohio
Whittaker Laboratories Inc., New York City 5
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Wyeth Incorporated 12
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Michell Farm, Peoria 65
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 64
North Shore Health Resort, Winnetka 66
Mary Pogue School, Wheaton, Ill. 67
Stokes Sanitarium, Louisville, Ky. 68

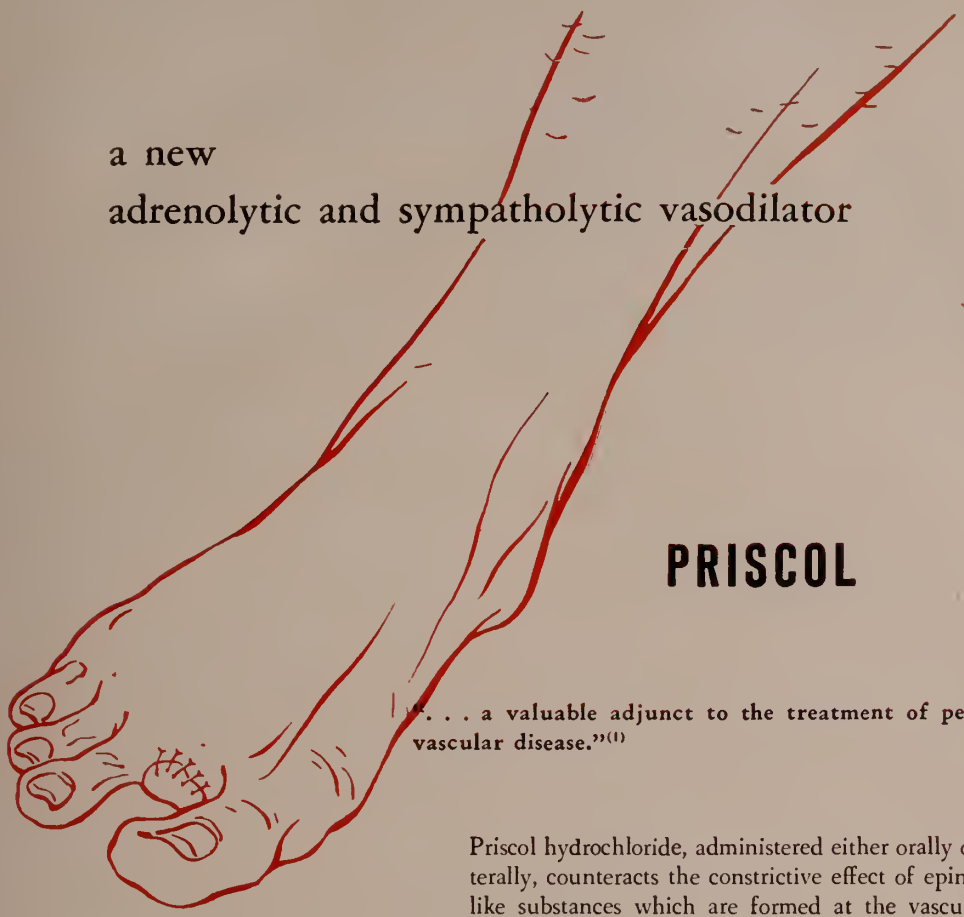
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1. Grimson, K. S., Marzoni, F. A., Reardon, M. J., and Hendrix, J. P.: *Surg.*, 23:728, 1948.

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sistance of Jacob Arlow, M.D., Raymond Hussey, M.D., Bertram Lewin, M.D., Robert C. Lowe, M. D., Sydney Rubin, M.D., E. Schneider, M.D., Lester W. Sontag, M.D., and Members of the Staff of the Departments of Medicine and Psychiatry, Columbia-Presbyterian Medical Center, New York City; The C. V. Mosby Company, St. Louis, 1948; 501 pages. $6.50.

ELEMENTARY ANESTHESIA: By W. N. Kemp, M.D. C.M., Consultant Anesthetist, Children's Hospital, Vancouver, B.C. The Williams & Wilkins Company, Baltimore, 1948; 289 pages. $5.00.

PRIMARY ANATOMY: By H. A. Gates, M.D., Professor of Anatomy, University of Toronto, The Williams & Wilkins Company, Baltimore, 1948; 478 pages. $6.00.

EDUCATION FOR PROFESSIONAL RESPONSIBILITY: A report of the Proceedings of the Inter-Professions Conference on Education for Professional Responsibility held at Buck Hill Falls, Pennsylvania, April 12, 13, and 14, 1948. Carnegie Press, Pittsburgh, 207 pages.

CONDITION REFLEXES AND NEURON ORGANIZATION: By Jerry Konorski, Head of the Department of Neurophysiology in the Nencki Institute of Experimental Biology and Professor in the University of Lodz; Translated from the Polish MS under the author's supervision by Stephen Garry, Cambridge University Press. The MacMillan Company, 60 Fifth Avenue, New York 11, New York; 267 pages; $4.00.

AN INTRODUCTION TO SURGERY: Fourth Edition, By Rutherford Morison, M.D., F.R.C.S. Edin., F.R.C.S. Eng., M.A., D.C.L., LL. D., formerly professor of surgery, Durham University and Charles F. M. Saint, C.B.E., M.D., M.S., F.R.C.S., F.R.A.C.S., formerly professor of Surgery, Cape Town University, South Africa; The Williams and Wilkins Company, Baltimore, 1948; 330 pages. $10.00

MALIGNANT DISEASE AND ITS TREATMENT BY RADIUM: By Sir Stanford Cade, K.B.E., C.B., F.R.C.S., M.R. C.P., Surgeon, Westminster Hospital, Mount Vernon Hospital and Radium Institute; Lecturer in Surgery, Westminster Hospital Medical School and formerly Examiner in Surgery, University of London; Member of the Court of Examiners, late Hunturian Professor and Arris and Gale Lecturer, Royal College of Surgeons of England; Member of the National Radium Commission and Trust; Consultant in Surgery to the Royal Air Force; with a foreword by Sir Ernest Rock Carling, F.R.C.P., F.R.C.S., F.F.R., Consulting Surgeon and Vice-President, Westminster Hospital. Volume 1; Second Edition. The Williams & Wilkins Company, Baltimore, 1948; 383 pages; $12.50.

ACUTE INTESTINAL OBSTRUCTION: By Rodney Smith, M.S.F.R.C.S., Assistant Surgeon, St. George's Hospital, London; Consulting Surgeon, Wimbledon Hospital; Hunterian Professor, Royal College of Sur-

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geons, with a Chapter on Radiological Diagnosis by Eric Samuel, M.D., F.R.C.S., F.F.R., D.M.R.E., Late Radiologist, The Middlesex Hospital, London; foreword by Rupert Vaughan Hudson, F.R.C.S., The Williams & Wilkins Company, Baltimore, 1948; 259 pages. $5.00.

THE STORY OF BLOOD: By John H. Glynn, M.D., A. A. Wyn, Inc., New York, 1948; 285 pages; $3.00.

A.M.A. INTERN'S MANUAL: W. B. Saunders Company, Philadelphia and London, 1948; 209 pages; $2.25.

PSYCHIATRY IN GENERAL PRACTICE: By Melvin W. Thorner, M.D., D. Sc., Assistant Professor of Neurology, The Graduate School of Medicine, University of Pennsylvania, W. B. Saunders Company, Philadelphia and London, 1948; 659 pages. $8.00.

THE SURGERY OF ABDOMINAL HERNIA: By George B. Mair, M.D., F.R.F.P.S.G., F.R.C.S.E., Surgeon, Law Junction Hospital, Lanarkshire, formerly First Assistant, Professorial Unit of Surgery, University of Durham, The Williams & Wilkins Company, Baltimore, 1948; 408 pages. $7.00.

HALLMARKS OF MANKIND: By Frederic Wood Jones, D. Sc., M.B., B.S., F.R.S., F.R.C.S., Sir William Collins Professor of Human and Comparative Anatomy in the Royal College of Surgeons of England. The Williams & Wilkins Company, Baltimore, 1948. 85 pages.

TECHNIC OF MEDICATION: By Austin Smith, M.D., C.M., M. Sc., Director of the Division of Therapy and Research; Secretary, The Council on Pharmacy and Chemistry, The American Medical Association. J. B. Lippincott Company, Philadelphia, London, Montreal, 255 pages. $4.00.

PERSONAL AND COMMUNITY HEALTH: Eighth Edition. By C. E. Turner, A.M., Ed. M., D. Sc., Dr. P.H., Professor of Public Health Emeritus Massachusetts Institute of Technology; Formerly Associate Professor of Hygiene in the Tufts College Medical and Dental Schools; Sometime Member of the Administrative Board in the School of Public Health of Harvard University and the Massachusetts Institute of Technology; Formerly Visiting Professor of Health Education, School of Public Health, University of California. The C. V. Mosby Company, St. Louis, 1948. 565 pages. $4.00.

TECHNIQUE OF TREATING FOR THE CEREBRAL PALSY CHILD: By Paula F. Egel, Cerebral Palsy Director, Children's Hospital, Buffalo, New York. Introduction by Winthrop M. Phelps, M.D., Medical Director, Children's Rehabilitation Institute, Baltimore, Maryland. Appendix by Moir P. Tanner, F.A.C.H.A., Superintendent, Children's Hospital, Buffalo, New York. Drawings by Dorothea Mintline. The C. V. Mosby Company, St. Louis, 1948. 203 pages. 49 illustrations. $3.50.

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The betatron, invented by Professor Donald W. Kerst of the University's physics department at Champaign-Urbana, is science's newest source of high-energy x-rays and electrons. The University of Illinois college of medicine will pioneer in the medical use of this instrument.

The grant by the American Cancer Society is one of the first expenditures to be allocated to Illinois for cancer research from funds raised in the 1948 national campaign. The grant will be used for the purchase and manufacture of accessory instruments required for accurate operation of the betatron.

Dr. Ivy explained that since the betatron was developed at the University of Illinois, the accessory equipment must be manufactured in their machine shops. Most of the equipment is electronic in nature. Dr. Ivy said, and requires the development of special circuits. They are for the purpose of measuring the intensity and quality of the x-ray beams emitted by the betatron and for setting up safety devices to protect the operators of the betatron. The accessory items have no commercial names.

Much of the accessory equipment is neccessary in carrying out research studies. The studies will be conducted by the department of radiology, under the supervision of Dr. Roger A. Harvey.

The 20-million volt betatron which is expected to be delivered to the University in November is manufactured by the Allis-Chalmers Manufacturing Company, Wisconsin. Its delivery will mark the world's first installation of a betatron for cancer treatment and research.

There is no Marxian method of eliminating gambiae mosquitoes as distinguished from a western democratic method. The principles of sanitary engineering do not bear a Russian or an American label. No difference exists between tuberculosis in the Soviet Union and tuberculosis in the United States. Infantile paralysis is the same thing in Moscow and in Washington, and human sorrow is no less poignant in one city than in the other. The world of disease and misery is not divided; it is a common world. In terms of human suffering the world is truly and tragically one world. Raymond B. Fosdick, Rockefeller Foundation Rev., 1947.

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POINTS OUT NEED OF ROUTINE EXAMINATION FOR STOMACH CANCER

Routine examination with x-ray films is the only effective means for discovering the majority of stomach cancers at an early stage, according to Leo G. Rigler, M. D., of the department of radiology and physical therapy of the University of Minnesota, Minneapolis.

Writing in the August 21 issue of The Journal of the American Medical Association, Dr. Rigler points out that "the procedure is capable of discovering most of the tumors present, even if of extremely small size.

"The vast majority of persons coming to surgical treatment are in an advanced stage of the disease so that surgical treatment is impossible in a high percentage of the cases.

"Surgical cures of carcinoma of the stomach will continue to be infrequent unless the diagnosis is made before the development of any appreciable symptoms or physical signs," he observes.

As the incidence of the disease rises sharply after the age of 50, such an examination is especially desirable for persons over that age, Dr. Rigler says.

For practical use of the examination on a wide scale, the group to be examined should be chosen by age and results of a preliminary test for gastric acidity, according to Dr. Rigler. If all persons past 50 were given a triple histamine test and a gastric analysis, and those for whom the analysis indicated a low gastric acidity were examined with x-ray films, most cancers of the stomach could be discovered, he points out.

Use of the preliminary gastric analysis would reduce the number of persons to be examined to approximately 30 per cent of the age group, he indicates.

In a study made by Dr. Rigler of 544 persons over the age of 50 who showed no symptoms of the disease but whose gastric analysis showed either absence of hydrochloric acid or less than 30 units of free hydrochloric acid, three stomach cancers and 19 "presumably benign" stomach polyps were discovered by routine x-ray examination.

The study was made during 1946 and 1947 in cooperation with the department of surgery and the out-patient department of the University of Minnesota.

Routine x-ray examination of only persons who show such possible indications of stomach cancer as gastric ulcer, pernicious anemia, and stomach polyps is not a solution of the stomach cancer problem, Dr. Rigler says. A large number of stomach cancers would still exist in persons showing no symptoms, he believes.

Fluoroscopy or examination by x-rays without a preliminary gastric analysis would not be practical for routine examination on a large scale because of the expense and personnel which would be required, according to Dr. Rigler.

Photofluorography "might constitute a fairly adequate examination and would be time saving and relatively inexpensive," he says.



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SKIN TEST INDICATES ALLERGY TO PENICILLIN

Persons who are to be treated with penicillin can be given a skin test which indicates whether they may have allergic reactions to the drug, say five researchers from the Dermatologic and Medical Services of the Mount Sinai Hospital, New York.

Writing in the October 30 issue of The Journal of the American Medical Association, the researchers — Samuel M. Peck, M.D., Sheppard Siegal, M.D., Arthur W. Glick, M.D., Abner Kurtin, M.D., and Rose Bergamini, B.A. — say that the test is a guide to treatment even in cases in which penicillin therapy must be started immediately.

Persons who have or have had fungous infection are especially likely to be sensitive to the drug, they point out.

The researchers recommend using the delayed reaction type of skin test, in which penicillin is injected just beneath the outer layer of skin. Reddening of the injection area 48 hours later indicates sensitivity to penicillin.

In a group of 276 adults who had never been treated with penicillin, 15, or 5.4 per cent, reacted positively to the penicillin skin test given by the reseachers.

Patients who are allergic to penicillin can be desensitized by giving them gradually increasing doses of the drug over a period of several weeks, the reseachers found. The desensitization is not always permanent, however.

PREVENTIVE MEDICINE AND PUBLIC HEALTH

When we stop to look at it, there are surprising similarities between public health and industrial medicine.

The physician actually working in the plant almost invariably becomes interested in prevention. As soon as the average doctor begins to see repetitious pathology, he automatically seeks a common cause. If a common cause can be discovered and eliminated, that is preventive medicine and public health. This is often, but not so universally, true of the physician who sees industrial cases in his office.

Preventive medicine on a mass scale is public health. The plant physician or industrial director is frequently referred to as the health officer of the plant.—W. P. Shepard, M. D., in Industrial Medicine.

"THE MORE WE OWN, THE LESS I'VE GOT"

Intriguing, indeed, is the story told about the woman of the British Isles who, when questioned about England's nationalization program, offered the following observations:

"This nationalization is a queer thing. We own the Bank of England now, but I am no better off. We own the coal mines, and I have less coal than I used to have. We own the railways, yet I cannot get a seat in a train. This socialism! The more we own, the less I've got."

Now that Britishers have a nationalized health plan, 1948 model, she probably could add: "We own medical services and the doctors, but I get second-rate care because my doctor just can't give much time to anyone of us since he has to see everybody on his panel as often as possible to keep from starving to death, God bless him."

An investment without dividends, we call it!

The Ohio State Medical Journal, Sept. 1948.

Vaccination with BCG does not provide complete protection against tuberculosis and, until further controlled studies are conducted, cannot be recommended for the general population. However, since it appears to provide some degree of protection, its use is recommended for members of groups constantly exposed to tuberculosis if they have a negative reaction to the tuberculin test. ATS Chemotherapy Comm., NTA, Nat. Tuberc. A. Bull., March 1948.

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SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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